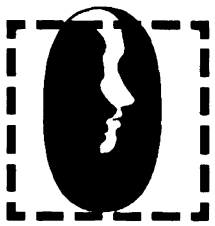
Long-Term Care of Tennessee's Elderly



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Executive Summary

This report is intended to provide an understanding of the issues involved in the long-term care of Tennessee's elderly. The report provides an overview of funding issues, details the various types of long-term care services, and explains some other states' long-term care programs. Because Tennessee's demographics indicate a significant near-term increase in the elderly population, this report seeks to impart a sense of urgency regarding the need to plan for long-term care services. The report concludes:

Much of the long-term care population is elderly. The elderly population in Tennessee and nationwide is increasing, and will soon increase dramatically. Approximately one in eight persons was elderly in 1994, but one in five will be elderly by the year 2030. The increase in the number of the elderly will be caused in part by the aging of the Baby Boomers. In addition, people are living longer, and the average number of years that the elderly population will require long-term care is increasing at a high rate. Persons aged 85 and older are the most likely of all elderly to need long-term care, and this age group is the fastest growing part of the elderly population. This population will more than double from three million in 1990 to seven million in 2020. The care needs of the elderly also increase as they age. Society cannot depend solely on adult children to care for the elderly. (See pages 1-9).

Tennessee has no comprehensive long-term care plan. The state should develop a plan now. Because of the increase of the elderly population, because their needs are so expensive, and because so many of them will be dependent on the state for their care, Tennessee must plan to care for its elderly in order to develop an effective and cost-efficient system of care. Numerous states, such as Oregon, Washington, Wisconsin, Arizona, Minnesota, and Georgia have successfully used home and community based services to provide efficient, effective services to their elders. (See page 10.)

There are various options available for funding a long-term care plan. A significant number of the elderly are and will be impoverished, and will rely on public funds for their long-term care. In 1990, 36 percent of Tennesseans, aged 65 to 74 and living alone, had incomes below the poverty level. A 1995 study performed by researchers at the University of Minnesota found that the percent of elderly in Tennessee with incomes below the poverty level, as well as the percent of elderly Tennesseans receiving Medicaid, to be relatively high. The majority of nursing home care in Tennessee is paid for by Medicaid, with Medicare paying for only limited long-term care services. Other financial support comes from the Social Services Block Grant (SSBG), the Older Americans Act (OAA), and Supplemental Security Income (SSI). (See pages 10-14.)

There are numerous types of long-term care services to consider in developing a long-term care plan. Each has benefits as well as detriments. Nursing homes have been the traditional providers of long-term care services. However, nursing home placement may not be appropriate in all cases, and other, less costly, home and community based alternatives may be more appropriate. Case management helps to facilitate and control access to services, and increases satisfaction among participants. However, case management may increase administrative costs. Respite care, which is relief provided to the caretaker of an elder, has been underutilized where it has been available. Although underutilized in Tennessee, these alternatives have been implemented on a much larger scale in other states. In order

to understand other states' efforts in the area of long-term care, a familiarity with the various types of long-term care services is essential. This report discusses hospices, homes for the aged, nursing homes, assisted-care living facilities, respite care, adult day care, personal care, homemaker, and chore services, home-delivered meals, as well as home care organizations such as home health agencies. (See pages 14-26.)

Home and community based services (HCBS) alone are not a panacea. In general, home and community based services, rather than institutionalization, are preferred by elders. However, in Tennessee, these services have not been viable alternatives to nursing home care. Tennessee ranks among the lowest states in the amount spent on HCBS per person age 65 and over. Tennessee also ranks among the lowest states in the percent of its total long-term care dollars spent on HCBS. There are various arguments for and against both HCBS and nursing home care. For example, although home and community based services are generally less costly than a nursing home stay, the cost of a few hours of home health care may be more expensive than the cost of a day's stay in a nursing home. Home and community based services should be thoughtfully and carefully planned and implemented. Criticisms of home and community based services might be resolved by clearly targeting groups of elders who might benefit most from these services. However, researchers disagree as to which groups might benefit most, making it difficult to determine which groups of elders to target. (See pages 26-27.)

Certain states, specifically Wisconsin, Oregon, and Washington, have effectively included home and community based services in their long-term care plans. These states have attempted to control the costs of long-term care by combining or replacing the use of nursing homes with various mixes of home and community based services. Additionally, some states have taken other successful measures such as implementing consumer-directed care attendant programs, utilizing case mix reimbursement, encouraging the use of long-term care insurance, heightening the eligibility requirements for admission into nursing homes or to be placed on Medicaid, using case management as a tool to shift elderly away from nursing homes into more appropriate and more cost efficient services, utilizing the managed care concept and/or capping expenses, and limiting the number of nursing home beds. Consideration of the successes and failures of these states' programs will prove instructive as Tennessee formulates its own long-term care plan. (See pages 27-31.)

Home and community based services have been successful in several states. However, there are many other approaches taken by states that have also been successful in managing the cost of long-term care:

- using case management as a tool to shift elderly away from nursing homes into more appropriate and more cost efficient services
- implementing managed care, such as Programs of All-Inclusive Care for the Elderly (PACE)
- implementing Social Health Maintenance Organizations (SMHO) Programs
- using case mix reimbursement
- implementing consumer-directed care attendant programs
- encouraging the use of long-term care insurance
- heightening the eligibility requirements for admission into nursing homes or to be placed on Medicaid

- limiting the number of nursing home beds
- estate recovery

(See pages 32-35.)

Conclusions and Alternatives

This report offers several conclusions and alternatives. (See pages 36-37.) Implementation of some of the alternatives could increase costs.

Tennessee must develop a comprehensive and focused plan for the long-term care of its elderly. A cohesive and focused policy, best administered through one agency, is necessary for Tennessee to be able to meet the demand for elder long-term care. The Department of Health, with the Commission on Aging, would be the ideal entities to administer a long-term care plan. The Department of Health contains the Bureau of TennCare, which administers Tennessee's Medicaid program, and would be the logical entity to apply for a Medicaid waiver, if it was prudent.

The state must gather more information before a plan can be developed. The number of underserved in Tennessee and what they need has not been determined. A demonstration project, based upon a statewide sample of Tennesseans, would be one way to find out this information.

In developing a long-term care plan, the state should consider:

- Utilization of home and community based services, with clear objectives and targeted populations of the elderly, would be the best way to serve people who are receiving little or no formal care and would reduce Medicaid expenditures for institutional care. However, providing services could cause people who had previously received no care to seek services.
- An extensive case mix reimbursement system could more efficiently utilize Medicaid dollars.
- Capping monies spent per service and/or per elder would reduce overall expenditures but might limit access to needed services.
- Heightened medical criteria and financial eligibility for nursing home admission and/or Medicaid would limit access to services and thereby help to contain costs.
- Case management helps to assure that elders are matched to the services that best suit their needs. Although several organizations, such as the area agencies on aging and the Tennessee Commission on Aging, provide information on Tennessee services for the elderly, a more proactive approach is necessary to best serve consumers and reduce expenditures.
- Consumer-directed care attendant programs could help reduce state costs and liability and allow the elder the independence to select his/her own caregivers.
- Encouragement of long-term care insurance, through legislation, could help shift the burden of long-term care from the public sector back to the private sector.
- More aggressive estate recovery could offset Medicaid expenditures.

Table of Contents

Introduction

Long-term care of the elderly is facing a crisis. The elderly population is increasing and will soon increase dramatically. Nationwide, approximately one in eight persons was elderly in 1994, but one in five will be elderly by the year 2030.

Tennessee's existing long-term care system is simply a patchwork of services. Nursing homes in Tennessee are the primary location for long-term care services, partly because of easy access, and the state and federal governments pay the majority of the cost. Most elders would prefer to remain in their homes, but there are few services that allow them to. Some states have developed effective and efficient long-term care systems, made up of various types of long-term care services. Information on these systems and services can be useful to Tennessee policy makers.

Methodology

The conclusions reached and recommendations made in this report are based on:

1. Interviews with personnel from federal, state, and local agencies and private enterprises.
2. Information received from federal, state, and local agencies and private enterprises.
3. Review of journal articles, books, and reports.
4. Analysis of census data.
5. Review of pertinent case law, Tennessee Attorney General's Opinions, and relevant statutes and rules and regulations.
6. Site visit of an adult day care center and a nursing home.

Background

Tennessee has no comprehensive long-term plan for the care of its elderly. However, elder long-term care has been a concern in Tennessee for some time. A 1995 study performed by researchers at the University of Minnesota found that the percent of elderly in Tennessee with incomes below the poverty level, as well as the percent of the elderly Tennesseans receiving Medicaid, to be very high. The study, *State LTC Profiles Report,* was commissioned by the U.S. Administration on Aging and performed under the auspices of the National Long-Term Care Mentoring Program at the University of Minnesota. The study compared the 50 states on various variables related to long-term care. Tennessee rated average compared to the other states for persons aged 85 and over as a percent of the total state population and average for the growth rate for that age group. However, the study concluded that the potential demand on Tennessee's public long-term care system was very high. Also, while the state's control of nursing home expenditures was above average, its commitment to home and community based services was very low.[1] (See Exhibit 1.) Since 1986, Tennessee has had a successful Medicaid demonstration program, the Shelby County Home and Community Based Services Waiver Project, but this program serves only a few hundred persons.

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[1]Richard C. Ladd, Robert L. Kane, Rosalie A. Kane, and Wendy J. Nielson, *State LTC Profiles Report,* National Long-Term Care Mentoring Program, Institute for Health Services Research, School of Public Health, University of Minnesota, 1995.

Exhibit 1
Long Term Care in Tennessee
Compared to Other States

Measure	Rate	Observations
Potential Demand on the Total LTC System	AVERAGE	Persons age 85+ comprise a comparatively average percentage of the total population, and the growth rate for this age group is also average. Percentage of elderly who live alone and the percentage who are minorities are both average. Prevalence of severe disabilities among the elderly is very high.
Potential Demand on the Total LTC System	VERY HIGH	Percentage of elderly with incomes below poverty level is very high. High percentages of elderly receive Medicaid. Prevalence of severe disabilities among persons age 18-64 is very high.
Control of Nursing Home Utilization	AVERAGE	Nursing home bed supply (per 1000 age 85+) is average. Nursing home occupancy and resident acuity levels are both high. High percentage of elderly reside in nursing homes. Growth rate for nursing home utilization during the 1980s was average.
Control of Nursing Home Expenditures	ABOVE AVERAGE	Medicaid nursing home costs per day are low. Amount spent on nursing home care per person age 65+ is also low. Growth rate for nursing home expenditures during the 1980s was low.
Commitment to HCBS	VERY LOW	Amount spent on HCBS per person age 65+ is low. HCBS expenditures comprise a very low percentage of total LTC expenditures.
Progress Toward an HCBS System	BELOW AVERAGE	Ranked 41st highest overall.

From *State LTC Profiles Report* by Richard C. Ladd, Robert L. Kane, Rosalie L.. Kane, and Wendy J. Neilson, National Long-Term Care Mentoring Program, Institute for Health Services Research, School of Public Health, University of Minnesota, 1995.

The projected increase in demand for long-term care services will result in huge expenditures for the state. For 1997-1998, total state and federal expenditures for long-term care for all age groups will be approximately $672 million. The combined state and federal expenditures for skilled and intermediate nursing care increased an average of 20 percent annually from 1988 through 1996. (See Exhibit 2.) However, for the last three years (1994-1996), that growth rate averaged only six percent. Based on a growth rate of six percent, the total annual state and federal long-term care spending in Tennessee would be approximately $767 million by the year 2000, and almost $2.5 billion by the year 2020. According to current Medicaid maximum reimbursement rates applicable in Tennessee, one year's stay in a nursing home ranges from $27,000 to $49,000. As of December 31, 1995, there were 37,959 licensed nursing home beds in Tennessee.

State Study Initiatives

The TennCare Long-Term Care Committee, headed by the Commissioner of Finance and Administration, was created in 1995 to review the problem of long-term care of the elderly. It was disbanded early in 1996 without offering any public recommendations. Also in 1995, the Tennessee General Assembly passed Senate Joint Resolution 58, which established a committee to study the feasibility of increasing the use of home and community based services as viable alternatives to nursing home care. The committee's report, "Home and Community-Based Long-Term Care as an Alternative to Nursing Home Care," was released in January 1997. Among its conclusions: (1) It is feasible to increase home and community based services (HCBS) in Tennessee, but the number of persons for whom such services could provide an alternative to institutional care is difficult to determine; (2) HCBS's impact on the cost and quality of care has not been proven in reliable statistical studies; (3) Available studies suggest that HCBS is unlikely to cause significant dollar savings; (4) The regulation of quality of care with HCBS could be problematic because of the number and variety of providers; and (5) Various options for payment or cost control may involve tradeoffs such as decreased patient/family choice and quality of care. The study recommended that home and community based services be tested on a limited basis such as a pilot study before implementing statewide.

Senate Joint Resolution 222, signed into law in June 1997, created a committee to study methods for increasing the availability and utilization of home and community based long-term care services for the elderly and the disabled and options for allocating public resources for such services. Additionally, the Tennessee General Assembly passed legislation, Chapter 381, Public Acts of 1997, which continues a respite care program in Gibson County.

Exhibit 2

State of Tennessee
Change in Skilled and Intermediate Care
Nursing Expenditures for the Elderly
Fiscal Years 1988-95

	Total State and Federal Spending		Percent
1988	$232,209,375		
1989	$240,472,514		4%
1990	$256.564,216		7%
1991	$347,554,918		35%
1992	$402,464,651		16%
1993	$505,659,786		26%
1994	$533,488,235		6%
1995	$567,437,295		6%
1996	$607,588,019		7%
Total Change	$373,378,644	162%	
Average Annual Change			20%

Source: Data from Bureau of TennCare, Tennessee Department of Health. Figures include federal matching funds. Figures do not include spending for home and community based waivers, payments made by patients, or Medicare crossover payments for persons eligible for both Medicaid and Medicare.

Analysis

Increasing Number of Elderly Tennesseans

The combination of rising numbers of elderly persons, longer life spans, and very high poverty rates among Tennessee's elderly could create major demands for long-term care spending in Tennessee. Much of the long-term care population is made up of the elderly. The population of elderly in Tennessee, and nationwide, is expanding and will increase at a dramatic rate. This may cause a crisis in the long-term care of Tennessee's elderly population. Approximately one in eight persons nationwide was elderly in 1994, but one in five will be elderly by the year 2030.[2] In addition, people are living longer, and the average number of years that the elderly population will require long-term care is increasing. The care needs of the elderly also increase as they age.

Tennessee's Growing Elderly Population

In 1993, 12.8 percent of Tennessee's population was aged 65 or older, compared to 12.7 percent nationwide.[3] By 2020, 17.5 percent of Tennessee's population is projected to be 65 and older.[4] As Appendix 1 shows, some states will be affected more than others by the increase in the number of elderly. Tennessee ranks 18th in the U.S. in rate of increase, with a projected increase of about 74 percent. The projected increase in Tennessee's population from 1993 to 2020 will be substantial:

- 104 percent for ages 55 to 64;
- 79 percent for ages 65 to 74;
- 56 percent for ages 75 to 84; and
- 105 percent for ages 84 and older. (See Exhibit 3.)

Some Tennessee counties already have experienced a significant increase from 1990 to 1995. Williamson County's elderly population, for example, increased 28.5 percent, Moore County, 26.2 percent, Cumberland County, 25.7 percent, Sevier County, 22.3 percent, and Meigs County, 22 percent. However, some rural counties experienced a decrease in the number of elderly. Clay County's elderly decreased by 10.4 percent and Lauderdale's decreased by 8.1 percent. (See Appendix 2.)

High Relative Poverty Rate Among Tennessee's Elderly

In 1989, Tennessee was among the eight states with the highest poverty rates for persons aged 65 and older.[5] (See Exhibit 4.) In 1990, over 26 percent of Tennesseans aged 75 and older had incomes below poverty level.[6] Of those living alone aged 65 to 74,

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[2]Frank B. Hobbs, *Sixty-five Plus in the United States*, 1996, p. 2-2.

[3]Tennessee Department of Health, *Tennessee's Health, Picture of the Present*, Part Two, 1993, at 1; Frank Hobbs, pp. 5-10.

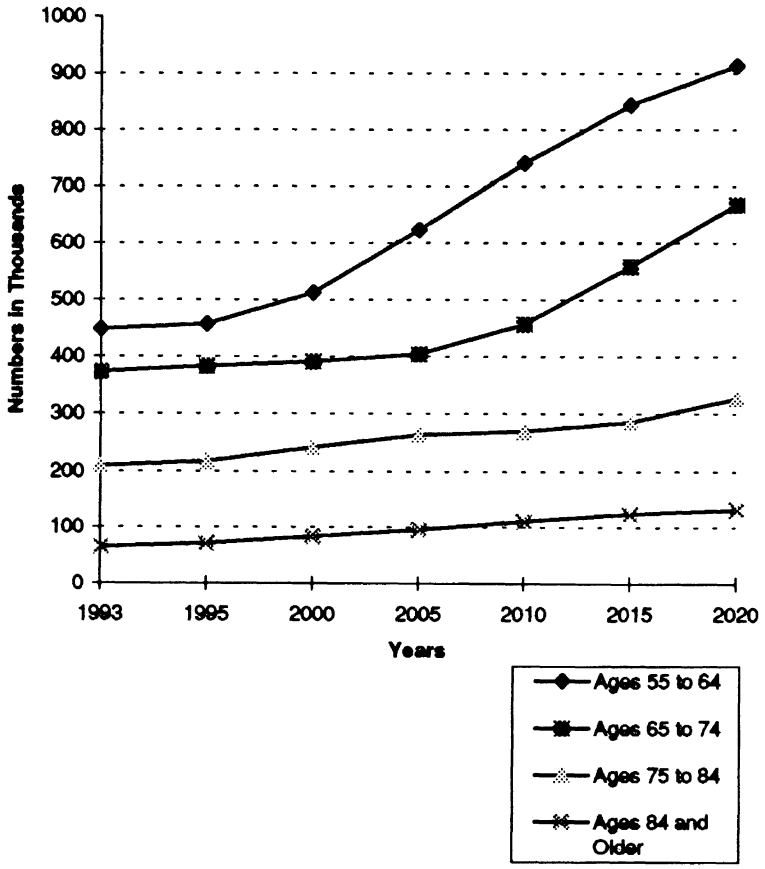
[4]Paul R. Campbell, *Population Projections for States, by Age, Sex, Race, and Hispanic Origin: 1993 to 2020*, 1994, pp. 24, 26, 28, 30, 32, 34, 36.

[5]Administration on Aging, *A Profile of Older Americans: 1995*, p. 4.

[6]Tennessee Commission on Aging, *Tennessee State Plan on Aging Under Title III of the Older Americans Act, Fiscal Years 1994-1995*, p. II-3.

Exhibit 3

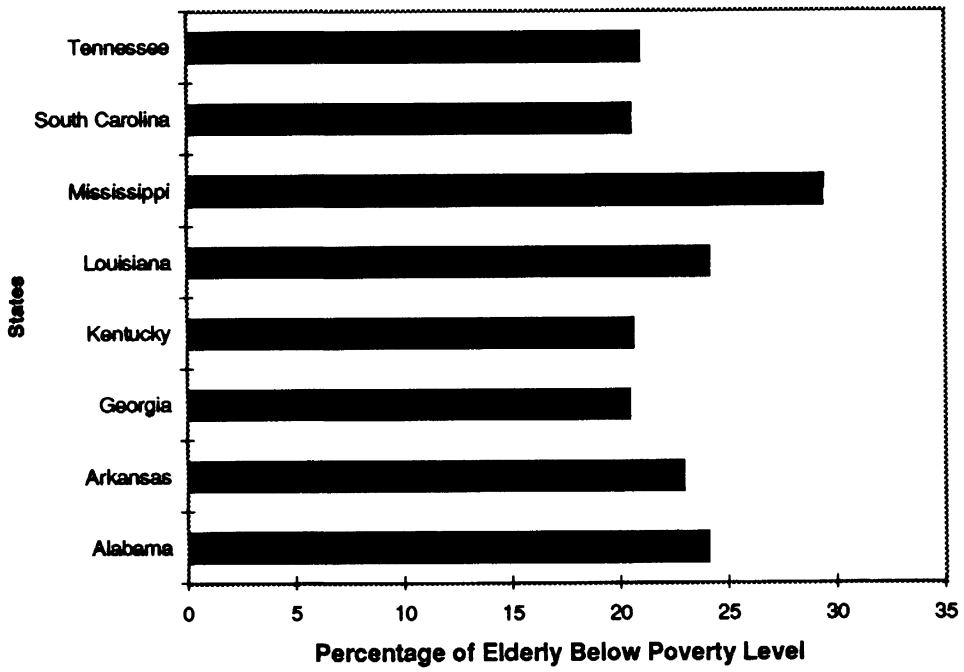
Tennessee's Aging Population



Year	Ages 55 to 64	% Change	Ages 65 to 74	% Change	Ages 75 to 84	% Change	Ages 84 and Older	% Change
1993	448		373		210		65	
1995	457	2%	383	3%	217	3%	71	9%
2000	512	12%	391	2%	242	12%	84	18%
2005	623	22%	405	4%	263	9%	96	14%
2010	741	19%	457	13%	270	3%	112	17%
2015	844	14%	559	22%	285	6%	125	12%
2020	913	8%	668	19%	327	15%	133	6%
% Change From 1993 to 2020		104%		79%		56%		105%

From the Bureau of the Census Current Population Reports, *Population Projections for States, by Age, Sex, Race, and Hispanic Origin: 1993 to 2020.*

Exhibit 4
States with the Highest Levels of Poverty for the Elderly as of 1989



State	Percentage of Elderly Below Poverty Level
Alabama	24
Arkansas	22.9
Georgia	20.4
Kentucky	20.6
Louisiana	24.1
Mississippi	29.4
South Carolina	20.5
Tennessee	20.9

From the Administration on Aging, *A Profile of Older Americans: 1995.*

over 36 percent had incomes below the poverty level.[7] Those elders with little or no family or community support rely on public funds for their long-term care. And once they are impoverished to the point that they rely on public funds, the elderly are not likely to leave the support of the government. The 1992 percentage of persons aged 65 and older below the poverty level ranged from 10.7 percent to 16.2 percent nationwide.[8] (See Exhibit 5.)

Increasing Life Spans

People are living longer, and the average number of years that people will need long-term care is increasing at a dramatic rate. Persons aged 85 and older are the most likely of all elderly to need long-term care. They comprise the fastest growing part of the elderly population. Nationally, this population will more than double from three million in 1990 to seven million in 2020.[9]

The increasing number of elderly can be attributed in part to the aging of the Baby Boomers. More than one million of the Baby Boomers (born between 1946 and 1964)[10] will live to be 100 years old.[11] Also, there has been a substantial decrease in the mortality rate, and a corresponding increase in life expectancy, attributable to advancements in medical technology, health education, and improvements in nutrition and living conditions.

The elderly are more likely to need long-term care because the mental and physical impairments that lead to dependency increase with age. Today, many people live long enough to experience multiple, chronic illnesses. In 1990, 10.5 percent of people aged 65 to 74 years and 51 percent of persons over the age of 85 nationwide needed help with Activities of Daily Living (ADLs).[12] ADLs generally include eating, bathing, dressing, getting to and using the bathroom, getting in and out of a bed or chair, and general mobility.

Soon people may spend more years caring for their elderly parents than they will spend raising their children. However, society cannot depend solely on adult children to care for the elderly because the retired population is growing faster than the working population, leaving fewer young people to care for the elderly. The burden of caring for an elder is greater and more unpredictable than caring for a child; child care decreases as the child ages, but the care needs of the elderly increase with age. This burden may be doubled in some families; there is a great likelihood of two generations of elderly persons in one family. The phenomenon of people raising their children and caring for their aging parents at the same time has given rise to the term "sandwich generation."[13]

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[7] Ibid.

[8] Hobbs, pp. 4-16 - 4-17, 4-22.

[9] Ibid.; Robert G. Colvard, Robert D. Hayes, Kenneth W. Hollman, "Gray America, Long-Term Care: Who pays and how much?" *Tennessee CPA*, November 1990, p. 9; Shelda L. Harden, "Long-term Care for the Elderly," *NCSL Legisbrief*, January 1996, p. 1.

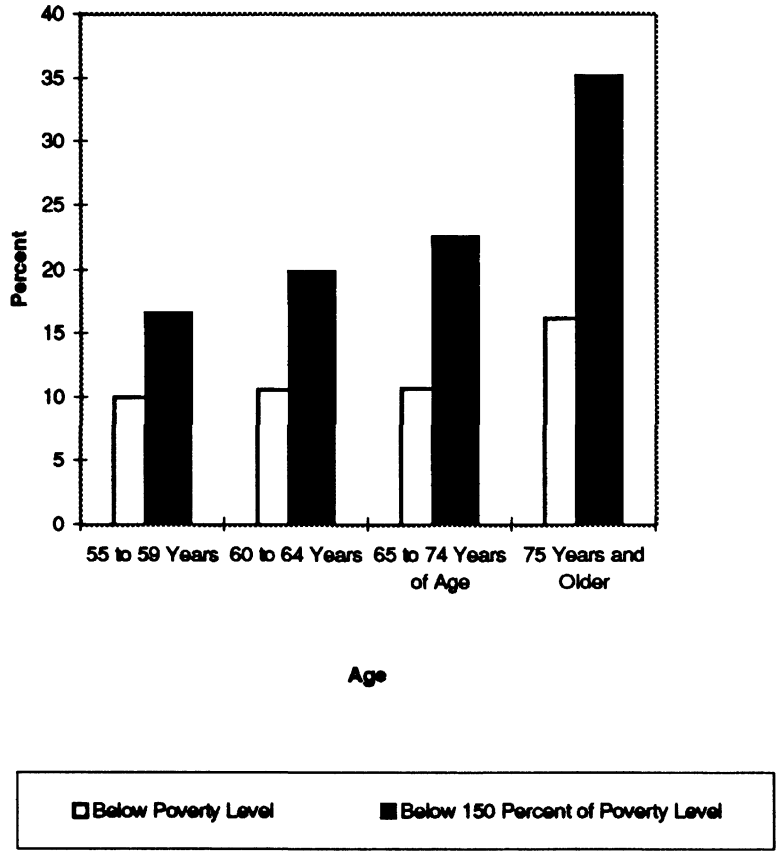
[10] Colvard, Hayes, and Hollman, p. 9.

[11] 1995 White House Conference on Aging, *The Road to an Aging Policy for the 21st Century, Executive Summary*, February 1996, pp. 17-19.

[12] Barbara Coleman, *New Directions for State Long-Term Care Systems, Volume I: Overview*, February 1996, p. 25.

[13] Hobbs, p. 2-19.

Exhibit 5
Percent Poor as of 1992 Nationwide



Age	Below Poverty Level	Below 150 Percent of Poverty Level
55 to 59 Years	10	16.6
60 to 64 Years	10.6	19.9
65 to 74 Years of Age	10.7	22.5
75 Years and Older	16.2	35.2

From the U.S. Department of Commerce, U.S. Department of Health and Human Services, *65+ in the United States,* 1996.

Need for a Long-Term Plan

Tennessee has no comprehensive long-term care plan. It would be prudent for the state to begin developing a plan now. Because of the increase of the elderly population, because their needs are so expensive, and because so many of them will be dependent on the state for their care, Tennessee must plan to care for its elderly in order to develop a system of care that will be effective and cost-efficient.

Some states have developed effective methods of providing long-term care for their elderly. Numerous states, such as Wisconsin, Oregon, Washington, Arizona, Minnesota, and Georgia have used home and community based services to provide efficient, effective services to more elders.

Funding for Long-Term Care

State officials must consider all available options for funding in developing a long-term care plan. A significant number of the elderly are and will be impoverished, and will rely on public funds for their long-term care. Most nursing home care in Tennessee is paid for by Medicaid, with Medicare paying for only limited long-term care services.

Five programs are the major sources of federal money available for the long-term care of the elderly: Medicaid, Medicare, the Social Services Block Grant (SSBG), the Older Americans Act (OAA), and the Supplemental Security Income (SSI) program.

Medicaid

Medicaid is the major joint federal/state program for financing elderly long-term care. Nationally, 20 to 25 percent of people who enter nursing homes as private pay patients convert to Medicaid.[14] Most nursing home care in Tennessee is paid for by Medicaid. In 1993, over 70 percent of Tennessee nursing home residents had their care paid for with Medicaid dollars.[15] Of those people who "spend down" their assets and become Medicaid eligible, the majority spend down within a year of nursing home admission. Exhibit 6 shows that in 1993, although long-term care comprised approximately 35 percent of national Medicaid expenditures, of all the Medicaid money spent on long-term care that year, 58 percent was spent on the elderly. Exhibit 7 depicts the Medicaid money spent nationwide on institutional and non-institutional care from 1987 through 1993.[16] Institutional care payments far exceeded the amount spent on noninstitutional care.

In Tennessee, Medicaid dollars have been used for home and community based services as offered through the Shelby County Home and Community Based Services Waiver Project. Medicaid home and community based service waivers can include noninstitutional services such as case management, personal care services, adult day care, respite care, and most other care that a state can show will lead to decreased costs for Medicaid funded long-term care.

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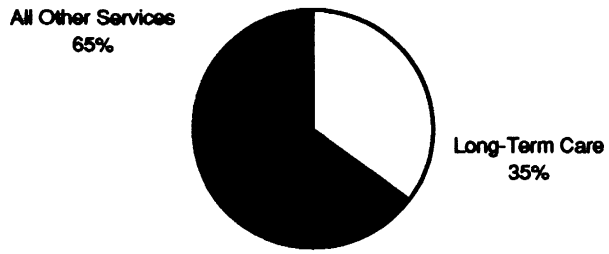
[14]1994 *Green Book: Overview of Entitlement Programs*, p. 23.

[15]Tennessee Health Care Association, *A Guide to Nursing Homes in Tennessee, 1993-1994*, 1993, p. 28.

[16]Kaiser Commission on the Future of Medicaid, *Policy Brief*, February 1996, p. 3.

Exhibit 6

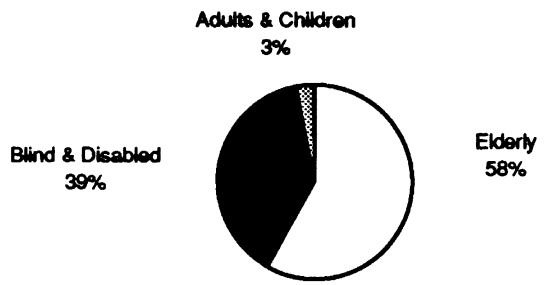
Figure 1
Long-Term Care as Percentage of Total Medicaid Spending 1993



Long-Term Care as a Percentage of Total Medicaid Spending, 1993

Service	Percentage
Long-term Care	35%
All Other Services	65%

Figure 2
Medicaid Long-Term Care Spending 1993



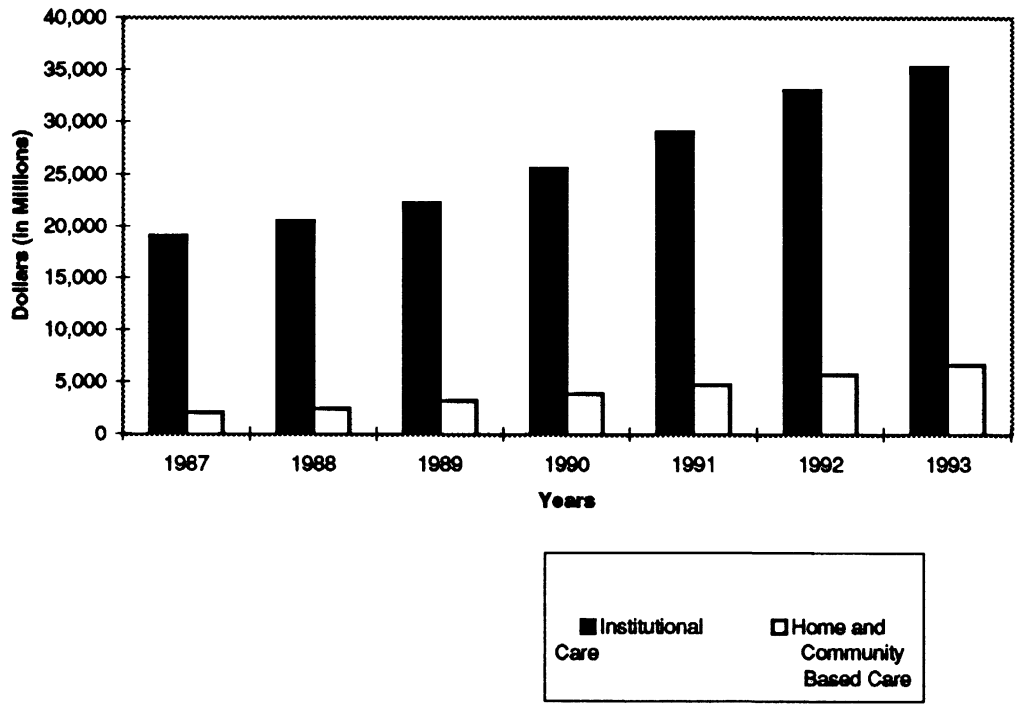
Medicaid Long-Term Care Spending, 1993

Population Group	Percentage
Elderly	58%
Blind & Disabled	39%
Adults & Children	3%

From the Kaiser Commission on the Future of Medicaid, *Policy Brief,* February 1996.

Exhibit 7

National Medicaid Expenditures for Institutional and Home and Community Based Care



	1987	1988	1989	1990	1991	1992	1993
	Millions of Dollars						
Institutional Care	19,068	20,532	22,296	25,625	28,994	33,065	35,286
Home and Community Based Care	2,069	2,448	3,257	3,925	4,758	5,761	6,662

From Mark V. Nadel, *Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs,* GAO/HEHS-94-167, August 1994.

Medicare

Medicare pays for only limited hospice and nursing home care. In 1992, 5.5 percent of Tennessee nursing home residents received Medicare in contrast to six percent across the United States.[17] Nursing home care under Medicare is limited to short-term stays in certain kinds of nursing homes and is available only for those who demonstrate a need for daily skilled nursing care following hospitalization. Medicare also pays for home and community based long-term care in the form of home health care.

Other

Other federal financial support comes from the Social Services Block Grant (SSBG), the Older Americans Act (OAA),[18] and Supplemental Security Income (SSI). The SSBG provides block grants to states for a variety of home based services for the elderly, the disabled, and children. The OAA funds a broad range of home and community based services. Since the establishment of the OAA in 1965, the level of federal funding has not kept pace with the mission of the OAA.[19]

In 1975, funding from Title XX was the only money available to support adult day care, but since that time Title XX money has greatly dissipated. This reduction in funding may be indicative of what has been described as "intergenerational crossfire," in which advocates for programs for families and children are pitted against advocates for the elderly.[20]

Under the SSI program, the federal government administers income assistance to the elderly, the blind, and the disabled. Many states supplement the federal payments to support selected community based long-term care services.

Types of Long-Term Care

The state should consider all types of long-term care services in developing a long-term care plan. Each of the long-term care services has benefits as well as detriments. Nursing homes have been the traditional providers of long-term care services. However, nursing home placement may not be appropriate in all cases, and other, less costly, home and community based alternatives may be more appropriate. Case management helps to facilitate and control access to services, and increases satisfaction among participants. However, case management may increase administrative costs. Respite care, which includes adult day care, is relief given to the caregiver of an elder. Respite care has been underutilized where it has been available.

There are various types of institutional and noninstitutional long-term care services. Although used only to a small extent in Tennessee, these alternatives have been im-

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[17]National Academy for State Health Policy, *Presentation to the TennCare Long-Term Care Committee*, February 20, 1996.

[18]The OAA expired in 1995. Although it did not renew the Act, Congress passed a continuing resolution which in effect, continues the OAA, including its mandates.

[19]Eleanor Chelimsky, *Older Americans Act - The National Eldercare Campaign*, GAO/PEMD-94-7, February 1994, p. 4.

[20]Gordon Bonnyman, *Role of Advocates in Long-Term Medicaid/Medicare Managed Care*, from the Long-Term Medicaid Managed Care Conference, May 1996, p. 2.

plemented on a much larger scale in other states. In order to understand other states' long-term care programs, a familiarity with the various types of long-term care services is essential. This report discusses hospices, homes for the aged, nursing homes, assisted-care living facilities, respite care, adult day care, personal care, homemaker, and chore services, home-delivered meals, as well as home care organizations such as home health agencies.

Federal law, through the Older Americans Act (OAA), mandates that certain programs must be provided by the states to their citizens. [21] The Tennessee Commission on Aging has designated an area agency on aging in each of the nine planning and service areas in Tennessee. Seven area agencies on aging are located in regional development district agencies, one is a human resource agency, and one is a regional commission on aging composed of local officials. Each of the nine area agencies on aging is the principal agent for carrying out the requirements of federal law for the care of the elderly.

The Tennessee Commission on Aging is required by the OAA to prepare a state plan on aging, which serves as a planning and compliance document for fulfilling its responsibilities under Titles II and VII of the Act, and each area agency on aging annually submits an area plan or update to the Commission on Aging. The OAA requires that the state plan specify a minimum percentage of the funds received that will be expended for access services, in-home services, and legal assistance. In 1992, approximately $2.9 million was spent on access services, over $915,000 for in-home services, more than $209,000 for community services, approximately $5.6 million for nutrition services, and almost $850,000 for the protection of elder rights.[22]

The OAA requires that the following programs be offered: congregate meals, home-delivered meals, information and referral programs, legal services, long-term care ombudsmen, and transportation services. The OAA services are contracted out from various area agencies on aging, and each area agency on aging offers other programs depending on local needs and available resources.

Case Management

Case management is an administrative process that allocates resources and theoretically lowers costs per person by substituting lower- for higher-cost types of services. Utilizing needs assessment, periodical reassessment, care planning, and service coordination, it both facilitates and controls access to services by requiring elders to go through a "gatekeeper" to receive care services.

Case management may increase administrative costs; however, research indicates that elders are more satisfied with a case-managed system, rather than receiving long-term care on an *ad hoc* basis. Single entry systems improve access to services and reduce duplication of services, thereby helping to control costs. Also, allowing local offices or agencies to operate as "gatekeepers" permits control of long-term care funds and services at a local level.

There are two major models of case management: direct service delivery and brokered service. In the direct service delivery model, the provider delivers directly using agency staff and is reimbursed for these services. In the brokered service model, the case management agency develops a care plan by working with many external providers and

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[21]Tennessee Commission on Aging, pp. I-1, I-3 - I-4, III-1 - III-28.

[22] Ibid. pp. I-10 – I-11.

arranges for the services to be provided. The brokered service model has been characterized as more difficult to implement while the direct service delivery model is relatively more efficient.[23]

Institutional Care

Hospices—T.C.A. 68-11-201(20) defines hospice services as a coordinated program of care providing emotional comfort and medical services to a hospice patient and his/her family in the patient's place of residence. A hospice patient must be diagnosed as terminally ill and have an anticipated life expectancy of six months or less. In 1993, there were 47 hospice providers in Tennessee.[24]

Homes for the Aged—In Tennessee, a home for the aged is a home that accepts elderly persons for relatively permanent domiciliary care and provides housing and personal services to one or more nonrelated persons.[25] As of FY 1996, there were 256 licensed homes for the aged in Tennessee with over 5,700 beds.[26] Exhibit 8 shows the Tennessee counties in which these homes are based. Shelby, Davidson, Hamilton, and Knox counties each have more than 20 homes for the aged as of 1996. Because Tennessee does not require homes for the aged to provide this information, it is not known if all these beds are filled.

Nursing Homes—In Tennessee, a nursing home is any institution, place, building, or agency for the express or implied purpose of providing care for one or more nonrelated persons who are not acutely ill, but require skilled nursing care and related medical services.[27]

The likelihood of being admitted to a nursing home increases with age, and therefore, the increasing elderly population means that more people will require long-term institutional care.

In 1990, three of four U.S. nursing home residents were aged 75 or older,[28] and the largest age group of nursing home residents are those 85 and older.[29] Nationwide, 90 percent of the nursing home population in 1990 were over the age of 65.[30]

Nationally, the number of nursing home residents is projected to increase almost 50 percent from 1985 to 2000, and 130 percent from 2000 to 2040.[31] As of 1992, almost 43 percent of persons aged 65 will need some nursing home care during their lifetime.[32]

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[23]Management Decision and Research Center, Department of Veterans Affairs, *Community-Based Long-Term Care, Resource Guide*, pp. 4-4, 4-19 - 4-20.

[24]Tennessee Department of Health, pp. I-J-1 - I-J-4.

[25]*T.C.A.* §68-11-201(13)(A).

[26]Board for Licensing Health Care Facilities, *November 1996 Directory of Licensed Residential Homes for the Aged in Tennessee* and *October 1996 Directory of Licensed Institutional Homes for the Aged in Tennessee.*

[27]*T.C.A.* §68-11-201(23)(A).

[28] Hobbs, pp. 6-9.

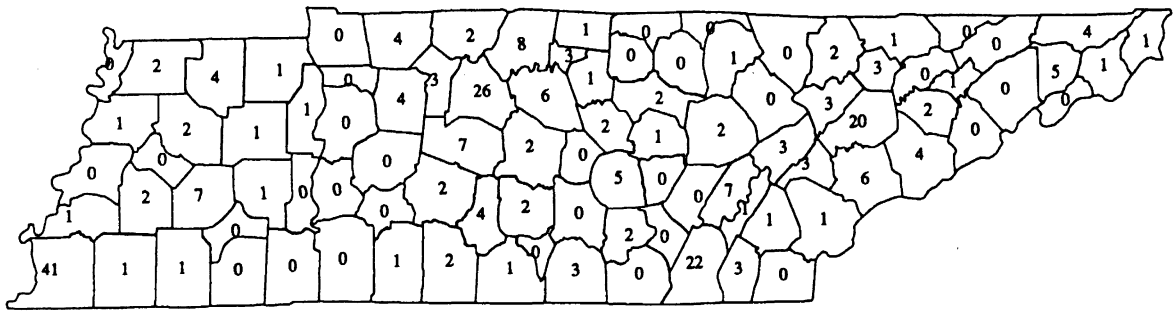
[29]Joe H. Murrey, Jr., Troy A. Festervand, Kenneth W. Hollman, "Attitudes of Older Adults Toward Long-Term Health Care Options," *Journal of the American Society of CLU & ChFC*, November 1992, p. 77.

[30] Hobbs, , pp. 6-9.

[31] Colvard, Hayes, and Hollman, p. 10.

[32] Murrey, Festervand, and Hollman, p. 71.

Exhibit 8
Tennessee Homes for the Aged by Base County in 1996



Anderson	3	Decatur	0	Henderson	1	Marion	0	Sequatchie	0
Bedford	2	DeKalb	2	Henry	1	Marshall	4	Sevier	4
Benton	1	Dickson	4	Hickman	0	Maury	2	Shelby	41
Bledsoe	0	Dyer	1	Houston	0	Meigs	1	Smith	1
Blount	6	Fayette	1	Humphreys	0	Monroe	1	Stewart	0
Bradley	3	Fentress	1	Jackson	0	Montgomery	4	Sullivan	4
Campbell	2	Franklin	3	Jefferson	2	Moore	0	Sumner	8
Cannon	0	Gibson	2	Johnson	1	Morgan	0	Tipton	1
Carroll	1	Giles	2	Knox	20	Obion	2	Trousdale	3
Carter	1	Grainger	2	Lake	0	Overton	0	Unicoi	0
Cheatham	3	Greene	0	Lauderdale	0	Perry	0	Union	3
Chester	0	Grundy	2	Lawrence	1	Pickett	0	Van Buren	0
Claiborne	1	Hamblen	1	Lewis	0	Polk	0	Warren	5
Clay	0	Hamilton	22	Lincoln	1	Putnam	2	Washington	1
Cocke	0	Hancock	0	Loudon	3	Rhea	7	Wayne	0
Coffee	0	Hardeman	1	McMinn	1	Roane	3	Weakley	4
Crockett	0	Hardin	0	McNairy	0	Robertson	2	White	1
Cumberland	2	Hawkins	0	Macon	1	Rutherford	2	Williamson	7
Davidson	26	Haywood	2	Madison	7	Scott	0	Wilson	6

From the Tennessee Board for Licensing Health Care Facilities, *October 1996 Directory of Licensed Institutional Homes for the Aged in Tennessee* and *November 1996 Directory of Licensed Residential Homes for the Aged in Tennessee.*

In 1995, approximately 45,000 persons of all ages in Tennessee received care in 336 nursing homes, an increase from approximately 39,000 in 1994.[33] Exhibit 9 shows the Tennessee counties in which these nursing homes are based. Shelby and Davidson counties have significantly more nursing homes than other counties, with 32 and 29 respectively, but almost every county has at least one nursing home.

In 1993, Tennessee nursing homes had a 95 percent occupancy rate,[34] and there were waiting lists for nursing home beds. It is difficult to ascertain the total number of people on nursing home waiting lists partly because of the federal court's decision in *Linton v. Commissioner of Health and Environment,*[35] where the court found Tennessee's limited bed policy (where nursing homes were allowed to decertify Medicaid beds in spite of waiting lists) to be in violation of federal law, and because many people are on more than one waiting list.

Certificates of need are required for any increase in the number of nursing home beds in Tennessee. As depicted in Exhibit 10, from 1990 to 1995, an average of 59 percent of the requests for certificates of need were granted.[36] Although the number requested increased at a regular pace between 1990 and 1993, with a large jump in 1994, the approval rate has varied widely.

Assisted-Care Living Facilities—Assisted-care living facilities (also known as continuing care retirement communities or CCRCs) are apartment-style arrangements, with home care services offered as a resident's condition changes. In Tennessee, they are statutorily defined at *T.C.A.* § 68-11-201(4) and are required to be licensed.

Across the nation, approximately 350,000 people currently live in more than 1,200 CCRCs.[37] Nationwide, the monthly fees average $2,160 ($72 a day). As of July 1997, the state has not finalized the requirements for licensure and thus has not begun licensing assisted-care facilities; therefore, the number of facilities in Tennessee is not known.

Nationally, one third of CCRCs offer fully prepaid contracts for long-term care. A study released by the Vanderbilt Institute for Public Policy Studies revealed that CCRCs offering fully prepaid long-term care coverage reduced nursing home use by 13 percent.[38]

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[33]Tennessee Department of Health, *Joint Annual Report of Nursing Homes in Tennessee* December 1995; Of the 340 nursing homes, four did not submit reports to the TDOH. Tennessee Department of Health, *Joint Annual Report of Nursing Homes in Tennessee*, December 1994.

[34]Tennessee Department of Health, *Tennessee's Health, Picture of the Present, Part Two*, p. 4.

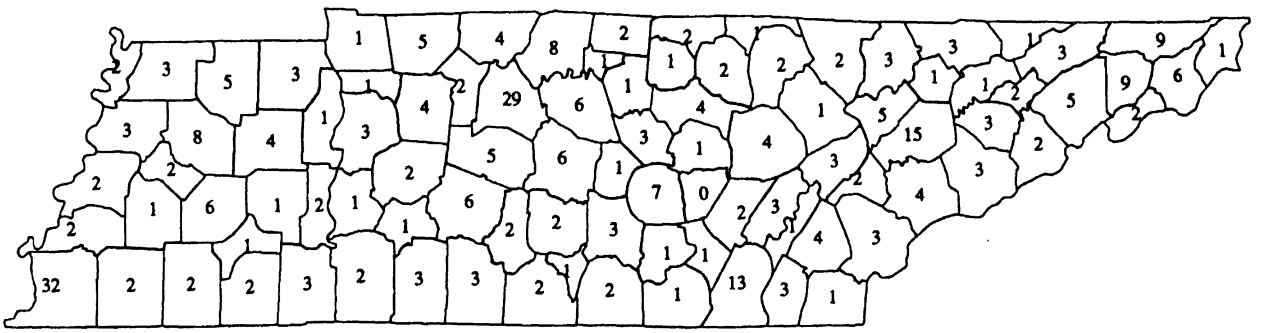
[35]65 F.3d 508, 511-512 (6th Cir. 1995).

[36]Tennessee Health Facilities Commission submitted to the Fiscal Review Committee, *Review of Nursing Home Bed Growth*, September 14, 1995, Chart A.

[37]William J. Scanlon, *Health Care Services, How Continuing Care Retirement Communities Manage Services for the Elderly*, GAO/HEHS-97-36, p. 1.

[38]Frank A. Sloan, May W. Shane, and Christopher J. Conover, "Continuing Care Retirement Communities: Prospects for Reducing Institutional Long-Term Care, Journal of Health Politics," *Policy and Law*, Vol. 20, No. 1, Spring 1995, p. 75. They derived most of their data from the National Continuing Care Data Base, a joint project of the American Association of Homes and Services for the Aging and Ernst and Young.

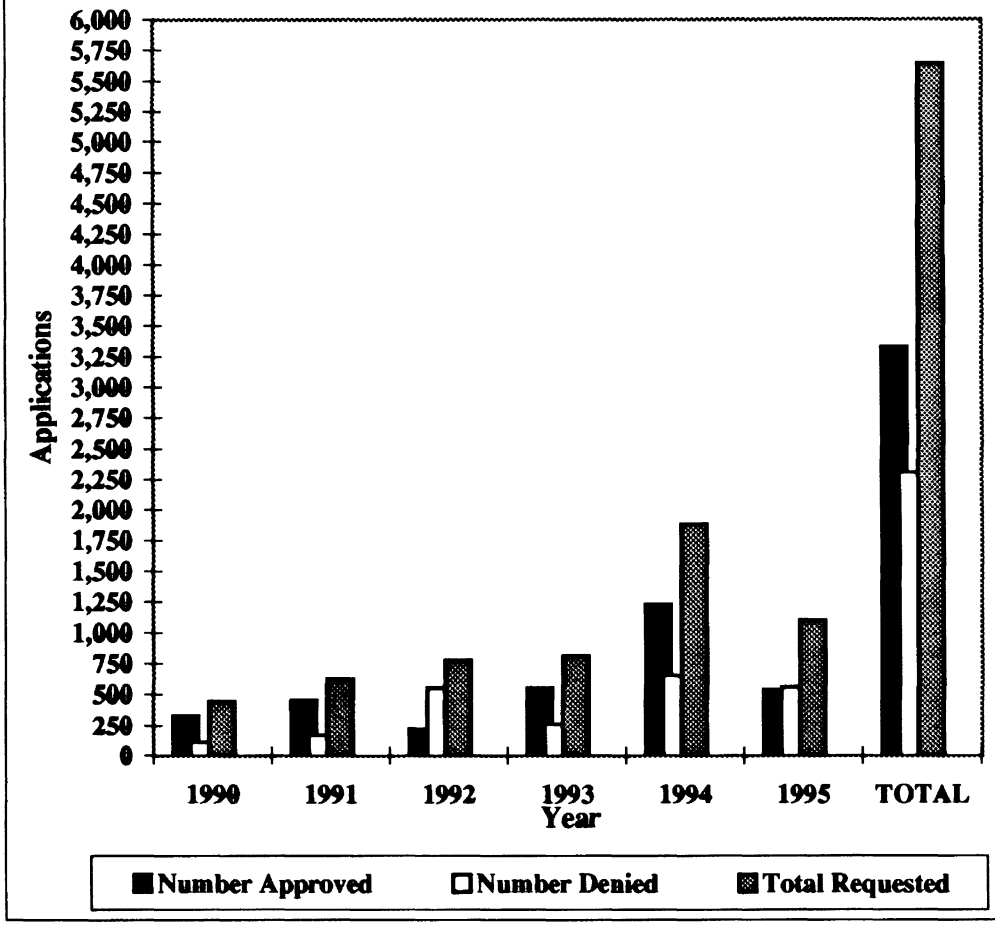
Exhibit 9
Tennessee Nursing Homes by Base County in 1995



Anderson	5	Decatur	2	Henderson	2	Marion	1	Sequatchie	1
Bedford	2	DeKalb	1	Henry	3	Marshall	2	Sevier	3
Benton	1	Dickson	2	Hickman	2	Maury	6	Shelby	32
Bledsoe	2	Dyer	3	Houston	1	Meigs	1	Smith	1
Blount	4	Fayette	2	Humphreys	3	Monroe	3	Stewart	1
Bradley	3	Fentress	2	Jackson	1	Montgomery	5	Sullivan	9
Campbell	4	Franklin	4	Jefferson	3	Moore	1	Sumner	8
Cannon	1	Gibson	8	Johnson	1	Morgan	1	Tipton	2
Carroll	4	Giles	3	Knox	15	Obion	3	Trousdale	1
Carter	6	Grainger	1	Lake	2	Overton	2	Unicoi	2
Cheatham	2	Greene	5	Lauderdale	2	Perry	1	Union	1
Chester	1	Grundy	1	Lawrence	3	Pickett	1	Van Buren	0
Claiborne	3	Hamblen	2	Lewis	1	Polk	1	Warren	2
Clay	2	Hamilton	13	Lincoln	2	Putnam	4	Washington	9
Cocke	2	Hancock	1	Loudon	2	Rhea	3	Wayne	2
Coffee	3	Hardeman	2	McMinn	4	Roane	3	Weakley	5
Crockett	2	Hardin	4	McNairy	2	Robertson	4	White	1
Cumberland	4	Hawkins	3	Macon	2	Rutherford	6	Williamson	5
Davidson	29	Haywood	1	Madison	6	Scott	2	Wilson	5

From the *Joint Annual Report of Nursing Homes in Tennessee,* December 1995, Tennessee Department of Health

Exhibit 10
Tennessee Nursing Home Applications for Certificates of Need 1990-1995



Year	Number Approved	Number Denied	Total Requested	Approval Rate
1990	333	113	446	75%
1991	455	169	624	73%
1992	221	556	777	28%
1993	552	262	814	68%
1994	1,232	651	1,883	65%
1995	539	558	1,097	49%
TOTAL	3,332	2,309	5,641	59%

From the *Review of Nursing Home Bed Growth*, Tennessee Health Facilities Commission, Fiscal Review Committee, September 14, 1995.

Home and Community Based Services

The Health Care Financing Administration allows states to obtain waivers to provide home and community based services (HCBS) to individuals who would otherwise be institutionalized. Tennessee ranks among the lowest states for the amount spent on HCBS per person age 65 and over. Tennessee also ranks among the lowest states for the percent of its total long-term care dollars spent on HCBS. Home and community based services can be provided by states to persons who would otherwise qualify for Medicaid only if they were in an institution. The waivers are granted under Section 1915 of the Social Security Act and may be implemented statewide or in specific geographic areas. A state may request waivers of federal requirements in Section 1902 of the Act that deal with provision of services statewide, comparability of services, community income and resource rules, and rules that require providing services to all eligible persons in the state on an equal basis.

States are allowed flexibility to tailor the services in their program to serve the needs of the population to be served. Home and community based services allow an elder to continue living at home, while receiving care either at home or away from home. Home and community based services typically include respite care, adult day care, home-delivered meals, and personal care, homemaker, and chore services.

Respite Care—Respite care programs provide relief to the primary caregiver of an elderly person through services that allow the caregiver to be absent for a period of time. A wide variety of services fit under the concept of "respite care." Formal respite services include in-home sitters/companions, adult day care services, and overnight or short-term residential respite provided in an institutional setting. In 1995, formal respite care was available at 83 Tennessee nursing homes; in the previous year, this care was available at only 71 Tennessee nursing homes.[39]

Nationwide, it is documented that the number of people who were expected to participate in certain respite care programs did not, and that some programs failed from lack of participation. Lack of participation may be attributed to many factors, including the financial cost of respite care, an elderly person's fear of change and lack of cooperation, and the reluctance of a caregiver to admit that he/she needs help. This lack of participation is unfortunate, because where respite care has been used, it has had positive effects on caregivers and their families. Long-term caregiving can lead to a kind of stress known as "caregiver burden" or "caregiver burnout," and this stress impacts the caregiver's life at home and work.

Respite care may also be provided by informal networks of an elderly person's family and friends. Nationwide in 1991, approximately 75 percent of the aged long-term care recipients living in the community received only informal care.[40]

Adult Day Care—An adult day-care program, a kind of respite care, is typically a program that allows caregivers to drop off elders at an adult day-care center for a few hours,

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[39]Tennessee Department of Health, *Joint Annual Report of Nursing Homes in Tennessee*, December 1994 and December 1995.

[40]Congress of the United States, Congressional Budget Office, *Policy Choices for Long-Term Care*, at 9.

thereby allowing a period of relief. In Tennessee, adult day-care is statutorily defined as services provided to 10 or more adult recipients, for more than three hours per day, by a provider of such services who is not related to the adults, pursuant to an individualized plan of care designed to maintain or restore each adult's optimal capacity for self-care through medical or social services.[41] Adult day-care generally includes personal care, supervision, socialization and recreational activities adapted to compensate for physical and mental impairments and may include physical therapy.

Of all the respite programs, adult day-care is used the most. However, there is practically no public funding utilized for adult day-care in Tennessee. Nationwide, the cost of adult day-care averages $50 a day.[42] The Tennessee Commission on Aging has noted that although there has been interest in Tennessee in adult day-care, the lack of public funding sources (namely the Social Services Block Grant) has resulted in programs failing.[43] A few adult day-care centers in Tennessee have encouraged their use by working with employers to offer employee discounts.

The number of adult day-care centers has increased nationwide from 18 in 1974 to more than 3,000 in 1997.[44] Pursuant to *T.C.A.* § 71-2-402, passed in 1996, adult day-care centers in Tennessee are required to be licensed. As of June 1997, the Department of Human Services has received licensure applications from 32 centers. Unsurprisingly, there are fewer adult day-care centers than nursing homes in Tennessee. Exhibit 11 shows adult day-care centers in Tennessee by county, as reported to the Department of Human Services.

Personal Care, Homemaker, and Chore Services and Home-Delivered Meals—Personal care services, home-delivered meals, homemaker services, and chore services often prove useful in the long-term care of an elderly person. In Tennessee in 1994, 14,675 persons received home delivered meals.[45] Also in 1994, over 1,500 people received service from Tennessee homemaker programs, and 3,205 people were on waiting lists.[46]

Home Care Organizations—*T.C.A.* §68-11-201(12)(A) defines a home care organization as one that provides home health services, home medical equipment services, or hospice services to patients on an outpatient basis in their place of residence. By Tennessee law, home health services must be provided by an appropriately licensed health care professional or an appropriately qualified staff member of a licensed home care organization.[47]

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[41]*T.C.A.* § 71-2-401(1).

[42]National Council on the Aging, as cited in "Farewell to the Nursing Home," *Business Week*, February 17, 1997.

[43]Tennessee Commission on Aging, pp. III-18 - III-19.

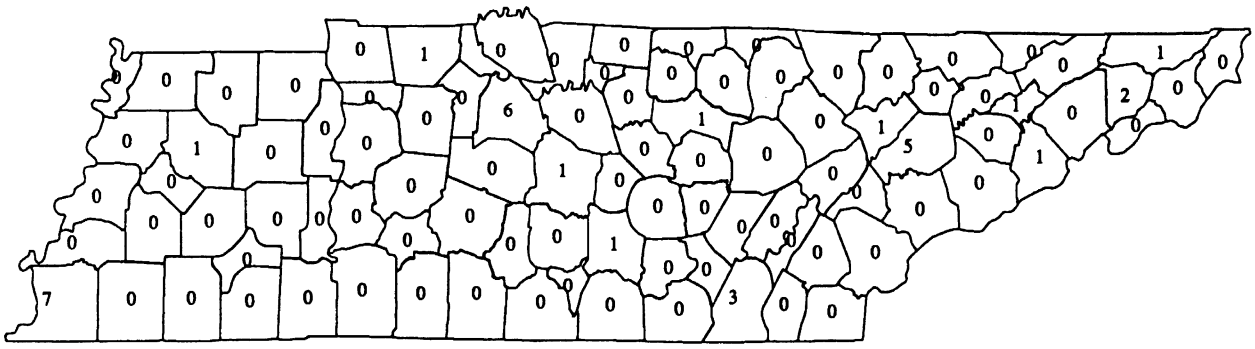
[44]American Demographics, *Where's the Day Care?*, July 1990, p. 17; National Council on the Aging, as cited in "Farewell to the Nursing Home," *Business Week*, February 17, 1997.

[45]Tennessee Commission on Aging, *Budget Improvement Request: FY 1996-97, Attachment #1, Services for the Frail Elderly*, p. 1. In 1994, Tennessee's Nutrition Program for the Elderly, provided hot meals served through 256 local congregate meal sites and home-delivered meal routes in the 95 counties.

[46]Ibid. p. 3.

[47]There are other conditions, set forth in *T.C.A.* 68-11-201(9)(A) and (10), applicable to home care organizations and home health services.

Exhibit 11
Adult Day Care Centers in Tennessee in 1997



County		County		County		County		County	
Anderson	1	Decatur	0	Henderson	0	Marion	0	Sequatchie	0
Bedford	0	DeKalb	0	Henry	0	Marshall	0	Sevier	0
Benton	0	Dickson	0	Hickman	0	Maury	0	Shelby	7
Bledsoe	0	Dyer	0	Houston	0	Meigs	0	Smith	0
Blount	0	Fayette	0	Humphreys	0	Monroe	0	Stewart	0
Bradley	0	Fentress	0	Jackson	0	Montgomery	1	Sullivan	1
Campbell	0	Franklin	0	Jefferson	0	Moore	0	Sumner	0
Cannon	0	Gibson	1	Johnson	0	Morgan	0	Tipton	0
Carroll	0	Giles	0	Knox	5	Obion	0	Trousdale	0
Carter	0	Grainger	0	Lake	0	Overton	0	Unicoi	0
Cheatham	0	Greene	0	Lauderdale	0	Perry	0	Union	0
Chester	0	Grundy	0	Lawrence	0	Pickett	0	Van Buren	0
Claiborne	0	Hamblen	1	Lewis	0	Polk	0	Warren	0
Clay	0	Hamilton	3	Lincoln	0	Putnam	1	Washington	2
Cocke	1	Hancock	0	Loudon	0	Rhea	0	Wayne	0
Coffee	1	Hardeman	0	McMinn	0	Roane	0	Weakley	0
Crockett	0	Hardin	0	McNairy	0	Robertson	0	White	0
Cumberland	0	Hawkins	0	Macon	0	Rutherford	1	Williamson	0
Davidson	6	Haywood	0	Madison	0	Scott	0	Wilson	0

From Information Provided by the Tennessee Department of Human Services, June 1997

Home Health Agencies—In fiscal year 1995-1996, 290 home health agencies in Tennessee provided care to more than 121,000 people over the age of 65.[48] Almost 53,000 people aged 75 to 84 and over 31,000 people aged 85 and older used home health services in Tennessee. (See Exhibit 12.)

Exhibit 13 shows the home health agencies in Tennessee by county. Almost all counties have home health agencies. The need for home health services is determined by the Tennessee Health Facilities Commission on a county by county basis, with 1.5 percent of the total population of a given county considered the need estimate.[49]

Institutional Care Versus Home and Community Based Services

Home and community based services alone are not a panacea. In general, home and community based services, rather than institutionalization, are preferred by elders. However, in Tennessee, these services have not been viable alternatives to nursing home care. There are various arguments for and against both HCBS and nursing home care. For example, although home and community based services are generally less costly than a nursing home stay, the cost of a few hours of home health care may be more expensive than the cost of a day's stay in a nursing home. Also, care in a nursing home is a complete "package" of services for one price, whereas a home and community based services patient would have to use several services for the same care. With the use of home and community based services, however, there will be administrative costs, and possibly an initial explosion in demand for the services as people take advantage of the newly offered services. Several states have successfully utilized home and community based services in their overall long-term care plans and have been able to serve more people more effectively and cheaply.

Home and community based services should be thoughtfully and carefully planned and implemented. Criticisms of home and community based services might be resolved by targeting groups of elders who might benefit most from these services. However, researchers disagree as to which groups might benefit most, making targeting difficult.

Institutional care, rather than home and community based long-term care services, accounts for the overwhelming majority of overall public expenditures for long-term care.[50] Nursing homes are the traditional location of formal long-term care services for the elderly. This may be partly because of society's emphasis on curing rather than caring for the individual. However, there are several issues concerning nursing home placement.

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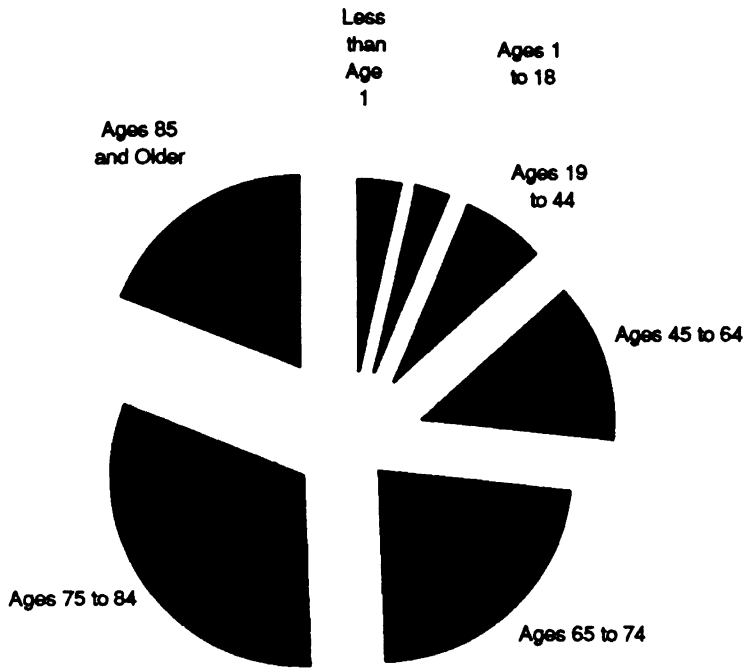
[48]Tennessee Department of Health, *Joint Annual Report of Home Health Agencies in Tennessee*, FY 1995-1996. Only 287 are based in Tennessee; three are based out of state.

[49]Tennessee Health Planning Commission, *Tennessee's Health, Guidelines for Growth, Criteria and Standards for Certificates of Need*, 1994, p. 41.

[50]Kaiser Commission on the Future of Medicaid, *Policy Brief*, February 1996, p. 2.

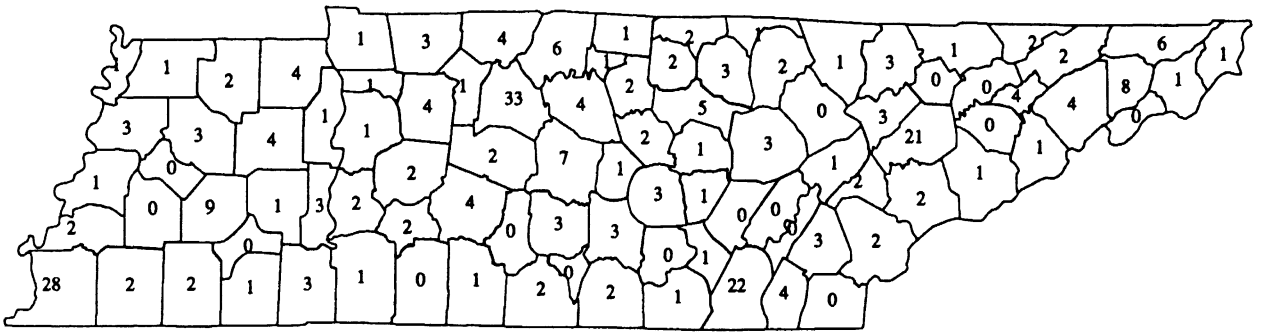
Exhibit 12
Tennessee Home Health Patients FY 1995-1996



Less than Age 1	Ages 1 to 18	Ages 19 to 44	Ages 45 to 64	Ages 65 to 74	Ages 75 to 84	Ages 85 and Older
5,986	4,751	11,313	22,267	37,730	52,773	31,207

From the *Joint Annual Report of Home Health Agencies in Tennessee,*
Tennessee Department of Health, FY 1995-1996.

Exhibit 13
Tennessee Home Health Agencies by Base County in 1996



County		County		County		County		County	
Anderson	3	Decatur	3	Henderson	1	Marion	1	Sequatchie	1
Bedford	3	De Kalb	2	Henry	4	Marshall	0	Sevier	1
Benton	1	Dickson	4	Hickman	2	Maury	4	Shelby	28
Bledsoe	0	Dyer	3	Houston	1	Meigs	0	Smith	2
Blount	2	Fayette	2	Humphreys	1	Monroe	2	Stewart	1
Bradley	4	Fentress	2	Jackson	2	Montgomery	3	Sullivan	6
Campbell	3	Franklin	2	Jefferson	0	Moore	0	Sumner	6
Cannon	1	Gibson	3	Johnson	1	Morgan	0	Tipton	2
Carroll	4	Giles	1	Knox	21	Obion	1	Trousdale	1
Carter	1	Grainger	0	Lake	1	Overton	3	Unicoi	0
Cheatham	1	Greene	4	Lauderdale	1	Perry	2	Union	0
Chester	0	Grundy	0	Lawrence	0	Pickett	1	Van Buren	1
Claiborne	1	Hamblen	4	Lewis	2	Polk	0	Warren	3
Clay	2	Hamilton	22	Lincoln	2	Putnam	5	Washington	8
Cocke	1	Hancock	2	Loudon	2	Rhea	0	Wayne	1
Coffee	3	Hardeman	2	McMinn	3	Roane	1	Weakley	2
Crockett	0	Hardin	3	McNairy	1	Robertson	4	White	1
Cumberland	3	Hawkins	2	Macon	1	Rutherford	7	Williamson	2
Davidson	33	Haywood	0	Madison	9	Scott	1	Wilson	4

From the *Joint Annual Report of Home Health Agencies* FY 1996, Tennessee Department of Health

Nursing Home Issues

- **The care offered in some of Tennessee's nursing homes may be questionable.** A 1997 federal investigation of Tennessee's largest nursing home, the Hamilton County Nursing Home, revealed severe cases of negligence and neglect.[51] These conditions raise questions concerning the adequacy of the safeguards and quality assurance measures offered in some Tennessee nursing homes.
- **People want to maintain their independence. When given the choice between institutional long-term care and noninstitutional long-term care, most elders prefer noninstitutional care.**[52]
- **Some nursing homes residents may not need nursing care.** In 1985, slightly more than 20 percent of nursing home residents nationwide had problems with only one Activity of Daily Living (ADL) or had no ADL problems at all.[53] These are people who would likely be better served by home and community services.
- **Nursing home care is expensive.** As of September 1997, the annual cost of a nursing home stay in Tennessee, based on Medicaid reimbursement rates, ranges from approximately $27,000 to $49,000.[54] Nationwide, a nursing home stay averages almost $39,000 per year ($105 per day).[55] By 2020, one projection of the annual cost of a nursing home stay, with expected inflation included, is $158,000.[56]

Home and Community Based Care Issues

All states offer some form of home and community based service to their elders. However, as many as 80 percent of the elderly nationwide who are in need of long-term care do not receive any formal care.[57] And there is clearly a demand for these services in Tennessee. Information compiled by the Frail Elder Services Coalition in 1994 documents the unmet demand for numerous elder care services in Davidson County, Tennessee.[58] However, Tennessee ranks second to last in the United States for money spent on home and community based services.[59]

- **Home and community based services are not always cheaper than institutional care.** Although nursing home care is expensive, neither is home health care inexpensive. Home and community based services generally cost less per hour or service than nursing home care. However, the hourly rate of home health care may be so high that a few hours of care are more expensive than 24 hours in a nursing home. Therefore, it is somewhat

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[51]Letter from Isabelle Katz Pinzler, Acting Assistant Attorney General, Civil Rights Division, U.S. Department of Justice, to Claude Ramsey, County Executive, Hamilton County, dated May 21, 1997.
[52]Kelly Schulman, National Association of Counties and National Conference of State Legislatures, *A New Look at Aging*, 1997, p. 4.
[53]1994 *Green Book: Overview of Entitlement Programs*, Appendix B, Chart B-8.
[54]From data compiled by Medicaid Audit, received July 22, 1996, confirmed September 12, 1997.
[55]National Council on the Aging, as cited in "Farewell to the Nursing Home," *Business Week*, February 17, 1997.
[56] Colvard, Hayes, and Hollman, p. 10.
[57]Coleman, p. 25.
[58]Frail Elder Services Coalition, *Frail Elderly Data Review*, 1994. There were waiting lists for housing and nutrition, transportation, respite care, adult day care, and homemaker services.
[59]Richard C. Ladd, Robert L. Kane, Rosalie A. Kane, Wendy J. Nielson, *State LTC Profiles Report*, 1995, Table 18.

misleading to compare the cost of home and community based services to the cost of nursing home care. Nursing home care is a complete "package" and includes case management, housing, food, and health services. A home and community based services patient would have to obtain services from numerous sources in order to meet the same needs. Nationwide, home health care averages $78 per visit.[60]

- **For all their benefits, home and community based programs may initially raise total long-term care costs, because of an initial rapid growth among elders seeking to use services that were previously unavailable.** Also, long-term care costs may increase unexpectedly with the use of home and community based services resulting from the documented tendency for people to discontinue the use of informal care when formal care becomes available.

Critics of home and community based services argue that there is no documentation that respite care reduces institutionalization. There are indications that home and community based services delay nursing home admissions.[61] On the other hand, some studies have shown that home and community based services are not effective in delaying institutional placement.[62] Home and community based services may even expedite nursing home admissions by identifying elders who were previously receiving little or no care, and whose physical and mental health has deteriorated to the point that only nursing home care is appropriate.

One option could be to target those elders who may benefit more than others from home and community based services. However, there is a lack of consensus about the populations that are best helped by home and community based services. For instance, those who are already at risk of institutionalization are good candidates for home and community based services. On the other hand, there is a plausible argument for targeting those elders who may only need some help in order to delay the need for institutionalization.

The problems with home and community based programs may be alleviated with clearly articulated program objectives; carefully defined target populations; coordination with the acute care sector; effective case management; and prudent resource allocation and cost control measures. Although there may be problems with the use of home and community based services, some states have successfully included these services in their overall long-term care plan. As explained further below, these states have been able to not only control costs but also serve more elders in need of long-term care.

Home and Community Based Programs in Other States

Although it is difficult to predict the projected long-term care needs of the elderly, some states have been able to effectively include home and community based services in their long-term care plans. Federal law mandates that certain programs be provided by the states to their citizens. Apart from fulfilling these federal requirements, states have at-

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[60]National Council on the Aging, as cited in "Farewell to the Nursing Home," *Business Week*, February 17, 1997.

[61]Susan L. Ettner, "The Effect of the Medicaid Home Care Benefit on Long-Term Care Choices of the Elderly," *Economic Inquiry*, Vol. XXXII, January 1994, p. 104-105.

[62]Ibid., p. 104; David E. Wilder, "Evidence of Goal Achievement: Evaluating Respite Programs," *Respite Care*, 1991, p. 218.

tempted to provide long-term care services while controlling costs through numerous projects and programs. These projects were primarily developed after 1981, when Congress first authorized the granting of Medicaid waivers.

All states provide some form of community-based long-term care services. Tennessee's 1915(c) waiver program, Shelby County Home and Community Based Services Waiver Project, was found to be cost-effective in a 1994 performance audit by the Tennessee Comptroller's Office.[63] It was also found to provide quality of care and accessibility equivalent to the quality of that available under the regular TennCare program.[64] The Shelby County Project provides four basic services: case management, personal care services, home delivered meals, and minor home modifications. Although developed for a total of 400 participants, the program had an average of only 258 participants from 1989 through 1993.[65]

Wisconsin, Oregon, and Washington have been able to effectively utilize home and community based services in their long-term care plans to provide long-term care to their elderly.[66] Oregon has saved $227 million from 1979-1991 and $400 million from 1979-1995 in long-term care costs.[67] These states have attempted to control the costs of long-term care by combining or replacing the use of nursing homes with various mixes of home and community based services and were among the first to establish waiver programs and expand home and community based long-term care. From 1982 to 1992, the combined number of nursing facility beds in these states declined as they expanded the use of home and community based services.

In creating and expanding home and community based programs, each of these states has restricted growth, which at times has led to limited access to services. They control eligibility with the imposition of financial and functional impairment criteria, certificates of need, limitations on hours of service or dollar benefits per beneficiary, and case management.

Wisconsin—Wisconsin's long-term care plan is implemented by the Division of Health and by the Division of Community Services, both of which are within the Department of Health and Family Services. Wisconsin requires prior authorization for some services and has capped the number of new nursing home beds since 1972.

Offered statewide since 1986, the state funded Community Options Program (COP) fills the gap in situations when a consumer requires services not provided through Medicaid. The COP emphasizes case management and utilizes comprehensive assessments, care planning, and ongoing services. Additionally, Wisconsin uses Medicaid dollars

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[63]Tennessee Comptroller's Office, *Performance Audit, Medicaid Waiver Project, Shelby County Home and Community Based Services*, September 4, 1994, pp. 1, 8-9.
[64]Ibid. pp. 9-15
[65]Ibid. p. 5.
[66]Mark V. Nadel, *Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs*, GAO/HEHS-94-167, August 1994, pp. 1, 5; Jane L. Ross, *Long-term Care: Current Issues and Future Directions*, GAO/HEHS-95-109, April 1995, p. 17
[67]Lisa Maria B. Alecxih, Steven Lutzky, John Corea, The Lewin Group, Barbara Coleman, AARP Public Policy Institute, *Estimated Cost Savings From the Use of Home and Community Based Alternatives to Nursing Facility Care in Three States*, 1996, p. 4.

to relocate persons from nursing homes and to maintain at-risk people in the community. The state also has a Program of All-Inclusive Care for the Elderly (PACE).

Although the Community Options Program (COP) has been successful, Wisconsin's long-term care system is nonetheless confusing and hard to access. Wisconsin is attempting to correct these problems by offering long-term and primary care to the elderly as well as disabled children and adults under a new statewide managed care plan, which was described by one Wisconsin state employee as "COP on steroids."

Under this new plan, local agencies (Resource Centers) will provide one-stop shopping for information, counseling, and access to services and support. The Resource Centers will screen eligibility for long-term care benefits, counsel consumers about long-term care options, develop a personalized assessment and care plan, and enroll the consumers in the care management organization (CMO) of their choice. Both Medicaid eligible and noneligibles are included in this program, with Medicaid ineligibles being financially responsible for their own care. Although not in the initial plan, Medicaid eligibles who do not need long-term care will eventually receive primary and acute care through this program. In this program, the seriously and persistently mentally ill (SPMI) population would be served through a separate system but would be "linked" with the long-term care system.

One-stop shopping means that there will be one contact and access point for each consumer. Wisconsin anticipates that there will be not one, but many Resource Centers that offer one-stop shopping. Wisconsin has well-developed county offices on aging, and county offices and tribal governments are given first choice to become Resource Centers. Wisconsin anticipates that there will be one resource center per county in urban areas and one for several counties in rural areas. The state has over 70 counties, so there could be quite a number of Resource Centers. This is considered ideal since Wisconsin hopes that the Centers will offer localized and specialized service, although the plan mandates that certain minimal services will be offered by each Center.

The state will contract directly with the Resource Centers and not with the CMOs. To avoid conflicts of interest, Resource Centers will be separate from any CMO and may not be a direct provider of services. The CMOs will receive capitated payments for the services that they offer, and capitation amounts will vary based on the target group of the enrollees and their level of functional disability. In the initial stages of the program, the state will share the financial risk with the CMOs, with greater risk assumed by the CMOs in later stages.

Wisconsin anticipates that this program will be fully funded by pooling current public funding streams for institutional and home and community based long-term care services, along with funds for acute and primary health care services for long-term care adult, elderly, and child consumers. Wisconsin will seek approval from HCFA to pool Medicaid and Medicare dollars.

Oregon—The goal of Oregon's long-term care plan is to have four of every five elderly long-term care consumers served by home and community based programs rather than by nursing home placement. Currently, Oregon is the only state that serves more people in home and community based programs than in nursing homes. A single agency, the Senior and Disabled Services Division in the Department of Human Resources, is responsible for implementing Oregon's long-term care plan. The legislation behind the state's long-term

care plan supports this centralization of plan administration, although local control through area agencies on aging is also encouraged.

The state's long-term care system uses case management to inform and assess the elder, and develop a plan that meets with the elder's approval and meets his/her needs, while focusing on the use of home and community based services. In 1981, about 8,000 Medicaid patients lived in Oregon nursing homes; by 1993, this number had been reduced to 7,500.[68] During this period of time, the number of persons receiving long-term care in Oregon increased from 8,000 to 17,000.[69] As of 1992, Oregon had one of the lowest ratios in the country of nursing home beds to elderly persons aged 65 and older.

Oregon has adopted the policy that nursing homes are to be used "as a last resort" and has promoted the growth of assisted-care living facilities and adult foster homes. The state's assisted living program is funded by Supplemental Security Income (SSI) money combined with Medicaid dollars.

While the state has had a certificate of need requirement for the addition of new nursing home beds since 1978, Oregon's officials have felt that heavy controls on the nursing home industry are unnecessary, reasoning that people will choose home and community based services, if available, over nursing homes.

Oregon's long-term care system contains the following provisions:

- permits nurses to train and monitor persons who are not licensed health caregivers to provide specific medical services in an effort to save money
- requires routine preadmission screening
- sets limits on the rates paid to home and community based providers
- has a Social Health Maintenance Organizations (S/HMO) Program with fully and partially capitated HMOs
- mandates managed care enrollment

In addition, Oregon has also developed one of the most effective estate recovery programs in the nation. Its most popular program is its "client employed" program, in which the elder employs the provider of the long-term care service, while the Senior and Disabled Services Division authorizes the number of hours that the provider will work and processes the payment for those services.

Washington—The state of Washington has made a concerted effort to shift emphasis away from nursing homes and toward home and community based services. While Medicaid spending on nursing home care in Washington increased from $50 million in 1981 to almost $300 million in 1993, the number of people served by home and community services more than doubled over the same period of time. Washington's state-funded "Chore Services" program provides services for approximately 6,000 persons who are medically eligible for nursing home care but are not financially eligible for Medicaid.

A single state agency, the Aging and Adult Services Administration in the Department of Social and Health Services, is responsible for implementing Washington's long-term care plan. The state's plan includes four home and community based care programs for the elderly and persons with physical disabilities. The Community Options Program

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[68]Coleman, p. 6.
[69]Ibid.

Entry System (COPES) is a home and community based waiver program for persons with disabilities and serves approximately 5,000 persons a month.

Nursing home beds are taken "off-line" in Washington when occupancy levels reach a certain point. The state now bases nursing facility rate increases on the U.S. Health Care Financing Administration's index of nursing facility cost instead of facility reports of expenditures.

Kentucky—Kentucky has an extensive statewide long-term care system. In 1990, the Kentucky General Assembly doubled the budget of the Homecare Program from $8.5 to $16.3 million, and in 1991, 53 percent more elders received care.[70] In 1992, however, the increase in the number of people receiving care was only seven percent; in 1993, the number decreased by two percent; and in 1994, there was an increase of about one percent.

Florida—Florida has three forms of assisted living programs: adult foster care, adult congregate care facilities, and extended congregate care. These programs serve approximately as many people as nursing homes; in 1994, Florida had 71,000 nursing home beds and 62,000 adult congregate care facility beds.[71]

Arizona—The Arizona Long-Term Care System (ALTCS), which covers the developmentally and physically disabled as well as the elderly, provides a variety of institutional and community and home based services. These long-term care services are delivered by a network of seven program contractors in Arizona's 15 counties. The rates for services are capitated, blended rates that include nursing facility costs, home and community based services, acute medical care services, behavioral health services, and case management services.

Minnesota—Minnesota's 1115 Medicaid waiver program combines Medicaid and Medicare funding and service delivery. The Long-Term Care Options Project is a demonstration project that was implemented in January 1996, in seven Minnesota counties. The project combines Medicaid and Medicare dollars in an effort to offer comprehensive long-term care and acute care coverage.

Georgia—Georgia is currently pilot testing a program similar to Programs of All-Inclusive Care for the Elderly (PACE): Service Options Using Resources in Community Environments (SOURCE). (See page 32 for an explanation of PACE.) Georgia decided that PACE did not fill all of the state's needs. Officials did not want the program to be age limited and wanted a chance to intervene before clients became nursing home eligible. Georgia officials say that SOURCE (which costs $3,000 - $4,000 a year) has been successful in keeping elders out of nursing homes (which cost $14,000 - $20,000 a year in Georgia).

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[70]Kentucky Division of Aging Services, *Homecare Annual Report*, 1994, p. II.1.
[71]Coleman, p. 16.

Other Programs for Controlling Long-Term Care Costs

Home and Community Based Services have been successful in several states. However, there are many other approaches taken by states that have also been successful in managing the cost of long-term care:

- All-Inclusive Care for the Elderly (PACE) Programs
- Social Health Maintenance Organization (S/HMO)Programs
- Using case management as a tool to shift elderly away from nursing homes into more appropriate and more cost efficient services
- Using case mix reimbursement
- Implementing consumer-directed care attendant programs
- Encouraging the use of long-term care insurance
- Heightening the eligibility requirements for admission into nursing homes or to be placed on Medicaid
- Limiting the number of nursing home beds
- Estate recovery

Programs of All-Inclusive Care for the Elderly (PACE)

Concerns over cost, quality, and access to care have made managed care an attractive alternative to the traditional fee-for-service system. One of the managed care systems that states have tried with success are Programs for the All-Inclusive Care for the Elderly (PACE), a national managed care model. PACE programs provide comprehensive acute and long-term care services, and have a multidisciplinary approach to care planning and service delivery. The programs target frail elderly persons living in the community and attempt to help them continue living at home rather than in a nursing home.

PACE programs pool funds from both Medicaid and Medicare, and pay providers a fixed monthly capitation rate per recipient. All recipients' health services are received through their PACE program, including physician services, hospitalization, therapies, pharmacy, and equipment. If nursing home care becomes necessary, the program also provides placement services. Thirty-one states are considering or have implemented PACE programs. A study commissioned by the National PACE Association revealed that PACE programs reduce Medicaid spending by five to 15 percent and Medicare by 12 percent compared to fee for service.[72] However, the small size of PACE programs, problems in adjusting for case-mix and other factors make it difficult to compare the cost of PACE programs to traditional long-term care arrangements.

Social Health Maintenance Organization Programs (S/HMO)

Social Health Maintenance Organization (S/HMO) programs combine acute and community long-term care services. They have more limited services than PACE programs. These programs pool funds from Medicare, Medicaid, and member premiums and co-payments into a capitated rate. S/HMO programs have a yearly dollar cap for long-term care benefits, whereas PACE does not. S/HMO programs differ from PACE in that they offer fewer services, medical care and rehabilitation services are not under the control of the case management team, and they seek to serve all elderly and not just the most frail.

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[72]"Focus on . . . PACE: Meeting a Need," *State Health Notes*, Volume 18, No. 254, June 9, 1997.

The original S/HMO programs were implemented in Portland, Oregon; Minneapolis-St. Paul, Minnesota; Brooklyn, New York; and Long Beach, California. The Minneapolis program discontinued its participation in 1995 because it considered the program too costly to administer. Congress extended and established a second generation of S/HMO programs in 1990. S/HMO II programs are intended to expand and refine the basic program and financing goals of the original S/HMOs. S/HMO II programs have been authorized in California, Florida, Massachusetts, Minnesota, Nevada, and Oregon.

Case Management

Case management has been used specifically as a way to divert the elderly from nursing facility care. Numerous states have case management; these states include Colorado, Connecticut, Illinois, Indiana, Massachusetts, Maine, Nevada, New Jersey, Ohio, Oregon, Pennsylvania, North Dakota, South Dakota, Utah, Virginia, Washington, Wisconsin, and Wyoming.

Virginia uses the Uniform Assessment Instrument to determine a person's need for long-term care services. Oregon's Risk Intervention Program identifies persons who are at risk of institutional placement. Wisconsin presents Medicaid patients who seek nursing home placement with home and community based alternatives. Maine requires that Medicaid recipients who are assessed for nursing home care also be assessed for home and community based alternatives.

Case Mix Reimbursement

Besides offering home and community based services, other states have attempted to reduce their long-term care costs in creative ways. Under a case mix system, nursing home patients' needs are assessed, patients are classified by need, and nursing homes are reimbursed according to that need. Numerous states are classified as case mix states.[73] Although Tennessee has been cited as offering case mix reimbursement, the state does not categorize the levels of Medicaid reimbursement to the extent of case mix states.[74] The standard case mix classification system is made up of 44 levels.

Consumer-Directed Care Attendant Programs

Eleven states offer Consumer-Directed Care Attendant programs, in which the consumer receives a cash payment to purchase services in the community: California, Colorado, Maine, Michigan, Nebraska, New Hampshire, Oklahoma, Oregon, Texas, Washington, and Wisconsin. Some benefits of this program include empowering the consumer and enhancing consumer satisfaction; treating attendants as independent contractors or as employees of the consumer, which allows the state to avoid tort liability and permits the state to avoid paying benefits and taxes for the attendants; lowering payment rates through use of an independent attendant, rather than through an agency employing the at-

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[73]Delaware, Illinois, Kansas, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Jersey, New York, North Carolina, North Dakota, South Dakota, Vermont, Virginia, and West Virginia according to Kimberly Irvin Snow, *State Long-Term Care Programs at a Glance*, 1995, p. 3.

[74]Tennessee has two levels of Medicaid reimbursement; Tenn. Rules and Regs. Sect. 1200-13-1-.10, et seq., 1200-13-1-.13, et seq.

tendant; and generating state revenue if this program is implemented through the Medicaid program, because of the federal match.

Long-Term Care Insurance

Private long-term care insurance may be a promising private sector option for providing the elderly with protection for long-term care expenses. Currently, however, group health care policies pay less than two percent of all long-term care expenses.[75] Insurers have traditionally designed policies to limit their liability for paying claims. Furthermore, the price of premiums is generally very high, but the insurance industry believes that premiums would be more affordable if the pool of people to whom policies were sold was larger. However, many people wait until their sixties to purchase long-term care insurance, possibly because of unwillingness to face the possibility of need for long-term care or because of the mistaken belief that Medicare covers long-term care.

In an effort to encourage the use of long-term care insurance, new federal legislation permits tax deductions for individually paid premiums and for expenses not reimbursed by insurance.[76] To ensure the value of long-term care insurance policies and to guard against fraud and abuse, many states have adopted regulations for the long-term care insurance industry.

Several states have programs to encourage the purchase of long-term care insurance: California, Colorado, Connecticut, Indiana, New Hampshire, and New York. In each of these programs, when the insurance benefits are exhausted, those insured are automatically eligible for Medicaid. Critics of these programs point out that people who would otherwise be ineligible for public assistance are allowed to receive Medicaid.

Heightened Eligibility Criteria for Nursing Home Admission/Medicaid

Some states have heightened the financial and/or medical eligibility criteria that people must meet before they are eligible for nursing home admission. Some states use a score sheet to keep track of persons' disability levels: Arizona, Colorado, Florida, Illinois, Iowa, Kansas, Missouri, Nebraska, Oklahoma, West Virginia, and Wyoming. Other states (Alabama, Connecticut, Delaware, Maine, Massachusetts, Montana, New Hampshire, New Jersey, Ohio, Oregon, South Carolina, Utah, Virginia, and Washington) categorize impairments (in some cases by using ADLs) and require that a threshold level of impairment be met before nursing home care is authorized. Tennessee's Pre-Admission Evaluation (PAE) requirements have been both praised and criticized for their stringency.

Limiting the Number of Nursing Home Beds

Elimination or partial deregulation of states' CON requirements has been cited as a way to provide opportunities for companies to develop new products and to promote an increasingly competitive marketplace. On the other hand, some argue that a moratorium on the addition of nursing home beds is critical to keeping long-term care costs contained.

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[75] Colvard, Hayes, and Hollman, p. 11; Ross, p. 12.

[76] *The Health Insurance Portability and Accountability Act of 1996*, NCSL Health Committee Bill Summary, August 13, 1996, pp 1, 13; The Mercer Report, *New Health Law Offers Tax-Favored Long-Term Care*, Issue 61, September 19, 1996, p. 2.

As of 1995, 15 states had implemented moratoria on nursing home bed expansion. Connecticut buys back beds that received CON approval but have not been built. Tennessee has had certificate of need requirements for several years.

Estate Recovery

Estate recovery is another source of funding for long-term care services. Because the elder's home is an excluded asset in determining financial eligibility for Medicaid, states have the option of recovering Medicaid expenditures for nursing home care from the estate of the deceased Medicaid beneficiary, often made up primarily of the decedent's house.

One nationwide survey revealed that 55 percent of persons admitted to nursing homes still owned their own homes.[77] However, the survey results did not indicate whether or not the nursing home patient's spouse still resided in the home. As stated above, Oregon has one of the most aggressive estate recovery programs in the nation, but in 1993, it was only able to achieve a savings of 2.5 percent.[78]

Pursuant to 42 *U.S.C.* §1396p and *T.C.A.* §71-5-116, Tennessee has an estate recovery program. The Bureau of TennCare does not track nursing home patients against whose estates Tennessee may recover money, but begins recovery proceedings only if first notified. Of the almost $1.5 million expended by the state on nursing home care in 43 cases, the state recovered approximately $279,000, or 18.6 percent of the expenditures identified, in 1996.[79]

Familial Fiscal Responsibility

Imposing familial fiscal responsibility is prohibited by current federal law. However, in the early 1980s, Idaho took advantage of a Reagan Administration reinterpretation of the federal law and required adult children to contribute to the cost of Medicaid nursing home care for their parents. Idaho had an eight percent drop in applications for Medicaid nursing home care, and after the termination of the program, had an eight percent increase in applications.[80]

Although familial fiscal responsibility is currently prohibited, the federal government could change the law. In 1995, Congress required family contributions in its Medi-Grant proposal; however, the proposal was later vetoed by President Clinton.

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[77]Joshua M. Wiener, *Can Medicaid Long-term Care Expenditures for the Elderly be Reduced?*, 1996, p. 6.

[78]National Academy for State Health Policy, *Presentation to the TennCare Long-Term Care Committee*, February 20, 1996, p. 8.

[79]Information received from Tennessee Bureau of TennCare, January 27, 1997.

[80]Joshua M. Wiener, *Can Medicaid Long-term Care Expenditures for the Elderly be Reduced?*, 1996, pp. 12-13.

Conclusions and Alternatives

Following are the conclusions and alternatives that Tennessee should consider in order to prepare to meet the demand for long-term elder care:

Tennessee must develop a comprehensive and focused plan for the long-term care of its elderly. A cohesive and focused policy, best administered through one agency, is necessary for Tennessee to meet the demand for elder long-term care. The Department of Health, with input from the Commission on Aging, would be a likely choice. Should the state choose to accept responsibility for the care of its elderly, there would necessarily be costs involved in implementing such a plan. A special committee or commission could be established, either by the executive or legislative branch, to develop a plan. Or the decision could be tasked to a state agency.

The state must gather more information before a plan can be developed. The number of underserved in Tennessee and their needs have not been determined. A demonstration project, based upon a statewide sample of Tennesseans, would be the best way to determine this information.

In developing a long-term care plan, the implementation of some of these alternatives could create administrative costs. Nonetheless, with adequate and informed preparation and planning, state officials will be able to effectively address the impending crisis.

Utilization of home and community based services, with clear objectives and targeted populations of the elderly would be the best way to serve not only people who are receiving little or no care at all, but also some nursing home residents. In addition, it would reduce Medicaid expenditures for institutional care. However, this approach could lead to an initial increase in total long-term care costs, because of an initial rapid growth among elders seeking to use previously unavailable services. Some nursing home patients would be better served by home and community based services. Because home and community based services can be less costly than nursing home care, the state could reduce Medicaid expenditures for institutional care if these services were used as an alternative to nursing home care.

An extensive case mix reimbursement system could more efficiently utilize Medicaid dollars. Paying for only the care that the elder requires would be more cost-efficient than paying a flat rate per person or paying one of two flat rates.

Capping expenditures per service could reduce overall expenditures. Limiting expenditures would likely lead to reduced expenditures, at least in the short-term. Limitation of expenditures also means limiting service. The elderly population could receive lesser services than with a comprehensive, carefully planned system of care.

Tennessee's PAE requirements could include heightened medical and financial eligibility criteria for nursing home admission. This could decrease Medicaid expenditures, but could also limit access to services and care. Further, compared to other states, Tennessee has relatively stringent criteria.

Case management would help assure that elders are matched to the services that best suit their needs. Although several organizations, such as the area agencies on aging and the Tennessee Commission on Aging, provide information on Tennessee services for the elderly, a more proactive approach is necessary to best serve consumers and reduce expenditures.

Consumer-directed care attendant programs could help reduce state costs and liability. By assessing an elder's needs and then disbursing money to allow the elder to purchase the service that he/she needs, costs and liability could be less than if the state provided the services. Allowing elders to select their own caregivers would give them a sense of independence.

Encouragement of long-term care insurance, through legislation, could reduce state expenditures. Use of long-term care insurance could help shift the burden of long-term care from the public sector back to the private sector.

More aggressive estate recovery could also be utilized to reduce state Medicaid expenditures. The state could recover money spent on Medicaid recipients from their estates after death.

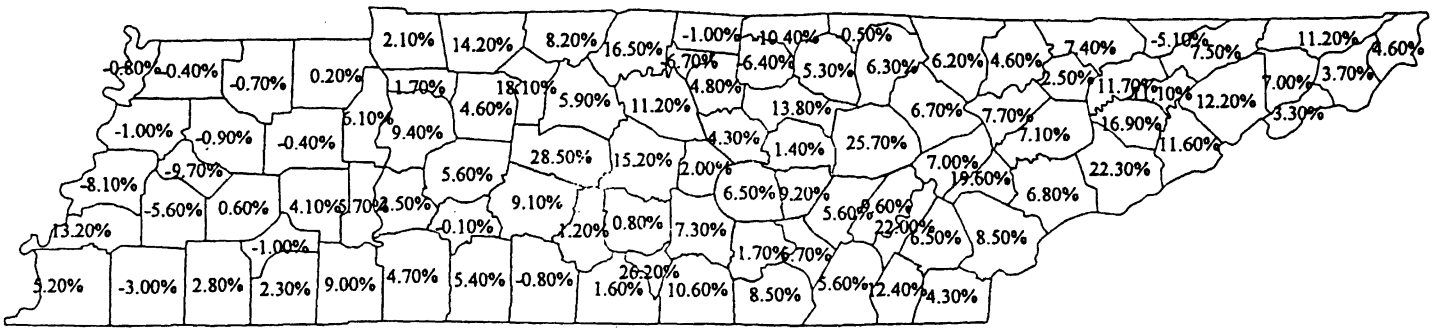
Appendix 1

Percent Change 1993-2020 of Persons Age 65 and Older

State	Percent Change	State	Percent Change	State	Percent Change	State	Percent Change
Nevada	115.6	N. Carolina	88.7	Montana	54.2	Michigan	34.9
Arizona	111.9	Virginia	85.3	Louisiana	52	South Dakota	34.3
Colorado	108	S. Carolina	84.9	Kentucky	51.3	Ohio	34.2
Georgia	104	New Hampshire	76.8	Oklahoma	50.4	Illinois	32
Washington	103.5	**Tennessee**	**73.5**	Maine	50.4	Massachusetts	31.7
Alaska	103.3	Oregon	73.2	Wisconsin	50	New York	26.8
Utah	102.4	Maryland	69.2	Kansas	46.5	Rhode Island	26.2
California	100.5	Delaware	67.2	Missouri	44.6	Iowa	25.1
Texas	98.4	Minnesota	61.5	Indiana	44	North Dakota	23.9
New Mexico	97.3	Alabama	60.4	Wyoming	43.4	West Virginia	23.1
Florida	96.2	Arkansas	60.1	Nebraska	38.5	Pennsylvania	20.7
Hawaii	91.6	Vermont	59.1	New Jersey	38.2	D.C.	13.2
Idaho	89.4	Mississippi	56.3	Connecticut	36.3		

From *65+ in the United States*, 1996, Frank B. Hobbs

Appendix 2
Changes in Population 65 Years Old and Older in Tennessee Counties, 1990-1995



	1990 Census	7/1/95 Estimate	Change 1990-95 Percent
Tennessee	615,725	658,214	6.90%
Anderson	10,488	11,294	7.70%
Bedford	4,530	4,567	0.80%
Benton	2,589	2,748	6.10%
Bledsoe	1,136	1,200	5.60%
Blount	12,595	13,456	6.80%
Bradley	8,137	9,144	12.40%
Campbell	5,113	5,350	4.60%
Cannon	1,588	1,619	2.00%
Carroll	4,928	4,910	-0.40%
Carter	7,801	8,090	3.70%
Cheatham	2,263	2,673	18.10%
Chester	1,922	1,903	-1.00%
Claiborne	3,370	3,618	7.40%
Clay	1,169	1,048	-10.40%
Cocke	3,740	4,173	11.60%
Coffee	5,586	5,995	7.30%
Crockett	2,533	2,287	-9.70%
Cumberland	6,097	7,661	25.70%
Davidson	58,795	62,269	5.90%
Decatur	1,972	2,084	5.70%
DeKalb	2,277	2,375	4.30%
Dickson	4,377	4,579	4.60%
Dyer	5,175	5,123	-1.00%
Fayette	3,301	3,201	-3.00%
Fentress	1,958	2,081	6.30%
Franklin	4,969	5,495	10.60%
Gibson	8,478	8,399	-0.90%
Giles	4,145	4,110	-0.80%
Grainger	2,197	2,455	11.70%
Greene	7,693	8,633	12.20%
Grundy	1,895	1,928	1.70%
Hamblen	6,008	6,674	11.10%
Hamilton	38,111	40,260	5.60%
Hancock	1,055	1,001	-5.10%
Hardeman	3,328	3,421	2.80%
Hardin	3,488	3,803	9.00%
Hawkins	5,857	6,294	7.50%
Haywood	2,994	2,826	-5.60%
Henderson	3,290	3,425	4.10%
Henry	5,480	5,493	0.20%
Hickman	2,331	2,462	5.60%
Houston	1,240	1,261	1.70%
Humphreys	2,298	2,515	9.40%
Jackson	1,586	1,484	-6.40%
Jefferson	4,406	5,149	16.90%
Johnson	2,254	2,357	4.60%
Knox	42,489	45,508	7.10%
Lake	1,058	1,050	-0.80%
Lauderdale	3,499	3,214	-8.10%
Lawrence	5,189	5,470	5.40%
Lewis	1,395	1,393	-0.10%

From Data Provided by U.S. Bureau of the Census to Tennessee Department of Economic and Community Development

	1990 Census	7/1/95 Estimate	Change 1990-95 Percent
Lincoln	4,348	4,418	1.60%
Loudon	4,552	5,446	19.60%
McMinn	6,059	6,451	6.50%
McNairy	3,606	3,689	2.30%
Macon	2,280	2,257	-1.00%
Madison	10,731	10,792	0.60%
Marion	3012	3268	8.50%
Marshall	3,259	3,299	1.20%
Maury	7,193	7,847	9.10%
Meigs	986	1,203	22.00%
Monroe	4,179	4,533	8.50%
Montgomery	7,932	9,055	14.20%
Moore	638	805	26.20%
Morgan	2,030	2,165	6.70%
Obion	4,915	4,896	-0.40%
Overton	2,701	2,844	5.30%
Perry	1,086	1,113	2.50%
Pickett	766	762	-0.50%
Polk	1,941	2,024	4.30%
Putnam	6,640	7,555	13.80%
Rhea	3,466	3,799	9.60%
Roane	7,053	7,548	7.00%
Robertson	5,032	5,445	8.20%
Rutherford	9,939	11,453	15.20%
Scott	2,180	2,315	6.20%
Sequatchie	1,094	1,167	6.70%
Sevier	6,371	7,793	22.30%
Shelby	85,658	90,083	5.20%
Smith	2,250	2,358	4.80%
Stewart	1,646	1,680	2.10%
Sullivan	20,413	22,709	11.20%
Sumner	10,421	12,138	16.50%
Tipton	4,044	4,577	13.20%
Trousdale	987	921	-6.70%
Unicoi	2,856	2,950	3.30%
Union	1,496	1,534	2.50%
Van Buren	585	639	9.20%
Warren	4,754	5,065	6.50%
Washington	12,826	13,726	7.00%
Wayne	2,050	2,146	4.70%
Weakley	5,155	5,121	-0.70%
White	3,218	3,262	1.40%
Williamson	6,643	8,537	28.50%
Wilson	6,561	7,298	11.20%

Appendix 3
Persons Interviewed

Lauren Barniski
Wisconsin Department of Health and Family Services

Bill Barrick, Legal Counsel
Tennessee Health Care Association

Gordon Bonnyman, Jr.
Tennessee Justice Center, Inc.

Barbara Coleman
AARP Public Policy Institute

Sam Dawson, Executive Director
Southwest Human Resources

Gretchen Foster, Network Coordinator
Senior Solutions

Dan Gray, C.E.O.
Alexian Village of Chattanooga

Lucy Hayes, Third Party Manager
Bureau of TennCare
Department of Public Health

Jim Heth, Family Services Program Specialist
Kentucky Division of Aging Services

Bob McFalls, Director
Delta Area Agency on Aging

Katie McMillan
Delaware Department of Health and Social Services
Division of Social Services/Medicaid

Ron Paolini, Assistant Director
Medicaid Audit
Tennessee Comptroller of the Treasury

Linda Penny, Executive Director
Tennessee Health Facilities Commission

Clarisse Reece, Director
Gibson County Commission on Aging

Paul Saucier
Muskie Institute of Public Affairs

Nancy Surchuk
Centennial Adultcare Center

Kathy Whitaker, Director
First Tennessee Area Agency on Aging

Emily Wiseman, Director
Charles Hewgley, Superintendent for Elder Rights Program
Commission on Aging

Steve Zagorski
President, Tennessee Association of Adult Day-Care
Executive Director, Centennial Adultcare Center

The National Long-Term Care Channeling Demonstration is a frequently cited project that emphasized case management and expanded access to community based long-term care for persons at risk for nursing home admission. The Adult Day Health Care Evaluation is a well-known study that evaluated the effects of increased access to community based long-term care for patients in the Veterans Administration system.